STATE OF CALIFORNIA

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

TRANSCRIPT OF PROCEEDINGS

STATE OF CALIFORNIA
MANAGED HEALTH CARE IMPROVEMENT TASK FORCE
Business Meeting
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2550 Mariposa Mall
Fresno, California 93271

Morning Session - 10:00 a.m.

REPORTED BY:
Kimberlee R. Miller,
CSR No. 10869
Our File No. 37162

APPEARANCES:

Alain C. Enthoven - Chairman

Dr. Phil Romero - Executive Director

Alice M. Singh - Deputy Director

Jill C. McLaughlin - Administrative Assistant

MR. ENTHOVEN: The meeting will come to order. I'd like to begin by asking Ms. Jill McLaughlin to call the roll. Jill.

MS. MCLAUGHLIN: Will the following members please signify their attendance by stating present.

Alpert.

DR. ALPERT: Present.

MS. MCLAUGHLIN: Armstead.

Bowne.

MS. BOWNE: Here.

MS. MCLAUGHLIN: Conom.

Decker.

MS. DECKER: Here.

MS. MCLAUGHLIN: Enthoven.

MR. ENTHOVEN: Here.

MS. MCLAUGHLIN: Farber.

Finberg.

MS. FINBERG: Here.

MS. MCLAUGHLIN: Gallegos.

Gilbert.

Griffiths.

Hartshorn.

MR. HARTSHORN: Here.

MS. MCLAUGHLIN: Hauck.

MR. HAUCK: Here.

MS. MCLAUGHLIN: Hiepler.

MR. HIEPLER: Here.

MS. MCLAUGHLIN: Karpf.

DR. KARPF: Here.

MS. MCLAUGHLIN: Kerr.

MR. KERR: Present.

MS. MCLAUGHLIN: Lee.

MR. LEE: Here.

MS. MCLAUGHLIN: Murrell.

Northway.

O'Sullivan.

Perez.

MR. PEREZ: Here.

MS. MCLAUGHLIN: Ramey.

Rodgers.

MR. RODGERS: Here.

MS. MCLAUGHLIN: Rodrigues-Trias.

DR. RODRIGUES-TRIAS: Here.

MS. MCLAUGHLIN: Severoni.

MS. SEVERONI: Here.

MS. MCLAUGHLIN: Spurlock.

DR. SPURLOCK: Here.

MS. MCLAUGHLIN: Tirapelle. Tirapelle.

Williams.

MR. WILLIAMS: Here.

MS. MCLAUGHLIN: Zaremberg.

MR. ZAREMBERG: Here.

MS. MCLAUGHLIN: Zatkin.

MR. ZATKIN: Here.

MS. MCLAUGHLIN: Thank you.

MR. ENTHOVEN: A quorum is present so we'll

proceed with the meeting.

As an ongoing effort to educate the Task Force about various aspects of managed care, today's program is about consumer protection as implemented by managed health care plans and will focus on two issues: Managed care environment around 1975 when the Knox-Keene Act was enacted, and a discussion of the Act's objectives and how it's been progressing; and then the second part will be a discussion consumer involvement communication and information.

We validated about 45 minutes of meeting time to each of these topics. On the first one Mr. Keith Bishop and Mr. Warren Barnes with the Department of Corporations will present the section on the Knox-Keene Act and task force member -- so Mr. Barnes and Mr. Bishop, thank you for coming.

MR. BISHOP. Thank you Mr. Chairman and as I said I'm Keith Bishop and to my right is Warren Barnes. Warren will speak first about the history and sort of antecedents of the Knox-Keene Act in California.

MR. BARNS: I will review, in very broad-breast fashion, historical information that virtually all of you are already familiar and put the Knox-Keene Act in some historical perspective.

The thread that runs through the history of managed care in California preceding and during the Knox-Keene Act era relates to problems associated with changes in financial incentives, in my judgment.

In the 1930s, you will recall was the first era of managed care, or in those days prepaid care in California. After a large number of companies were in business for a period, there was an enormous sake out in the marketplace, Kaiser and Ross Loose (phonetic) are two of the notables that continue today, Ross Loose under the name of Cigna at this time. Blue Cross also became happily ensconsed in Chapter 11 (a) of the Insurance Code during the 1930s. There are other companies as well.

In the 1960s, there was then experienced a resurgence of interest in managed care with a number of new entrants into the market; that was a cause for concern for some of the more established, obviously reputable companies, and they on their own industry initiative came together to seek legislation to regulate the managed care industry well aware that major problems in one area could tarnish the entire industry in the public mind. What resulted from that in 1965 was the Knox-Mills Health Plan Act that provided for registration of health care service plans. The administrator was the Attorney General. The regulatory program consisted of one person, by the name of Bob Obress (phonetic), who collected the registration statements that the plan submitted. Attorneys in the A.G.'s office were available for consultation.

Then in the late '60s, as you well know, then Governor Regan saw the wisdom of using prepayment as a mode for delivery of medical services that resulted in a large number of people entering the market for the first

time as prepaid health plans to serve the Medi-Cal population. There were a number of significant problems marketing quality of care, administration, etc., that were observed at that time, which resulted in 1972 in the enactment of the Waxman-Duffy Health Plan Act. That was the first formal consistent statutory authority for the Department of Health Services to contract with entities on a prepaid basis to provide services to Medi-Cal enrollees and also allowed DHS authority to monitor those contracts.

Now there were a number of problems that became steadily worse over a period of time. It was eminently clear, in retrospect, that the Knox-Mills Act of 1965 was utterly unsuited to, shall I say contain the entrepreneurial ferment that was associated with that prepaid health care, and in particular it was utterly unsuited to contain the ferment involved with the prepayment programs for Medi-Cal enrollees.

The Waxman-Duffy Act was widely understood in the capital as the solution to the problem, at least insofar as prepaid Medi-Cal was concerned. Unfortunately, this did not turn out to be the case. Knox-Mills and Waxman-Duffy together were unable to contain those problems. As a consequence, the legislature in 1975 enacted the Knox-Keene Health Care Service Plan Act. That act was designed to create a channel consisting of a variety systems that Commissioner Bishop will discuss later to regulate the health plan industry, commercial, Medi-Cal all aspects of the prepaid or managed care

business.

At that time, the legislature was presented with a problem. The attorney general had made it abundantly clear that he wished to have no more to do with the regulation of managed care. Consequently, it was necessary for the legislature to define a home for the Knox-Keene Act who would be the department in charge of it, the administration, and enforcement responsibilities. There were several considerations. In many states DOI regulates -- the Department of Insurance in many states regulates the managed care industry, that was rejected by the California legislature on the grounds that the managed care industry was a service industry exemplified by the term health care service plan as opposed to an indemnification industry and there was concern if the managed care industry were saddled with insurance-style regulation it would not be able to fulfill the objectives that the legislature had in mind for it. In specific, cost containment without deterioration and quality of care.

DHS was also an obvious possibility. There was concern with DHS that DHS was also a primary purchaser of services insofar as the prepaid Medi-Cal programs were concerned. That was a major hope for cost containment; there was a concern there might be a conflict of interest, it might be very difficult to encourage plans to contract with them at the same time to regulate them. There was less consideration given to Consumer Affairs, but the

perception was that Consumer Affairs, insofar as health is concerned, is primarily related with regulating professionals.

Department of Corporations ultimately was selected for two reasons. First, the Department had a long history of successful regulation of a large variety of different types of businesses ranging from broker dealers on the one hand to financial services companies and a number of other entities through the continuum. The second reason Department of Corporations was selected, is that it had its own enforcement capability, enforcement attorneys that worked over a wide variety, the entire range of laws that the Department is responsible for administrating, approximately twelve or thirteen in those days, so that if major problems arose in any one area the weight of the Department's enforcement capability could be directed in that area whether it was health law, securities law, or whatever it maybe. And there were a number of significant enforcement issues presented to the Department when it received jurisdiction under the Knox-Keene Act in 1975.

In keeping with my perception that the thread of history going back to 1930s with managed care had to do primarily with the change of financial incentives and the problems that frequently attended that, perhaps the main provision in the Knox-Keene Act that addresses that is 1367 (g) which requires medical decision making at all levels to be qualified and prohibits

interference of medical decision making by fiscal and administrative management.

One very brief comment in terms of the historical background by way of summing up. In a sense, we have come full circle on some issues and in particular some of the financial and some of the quality of care problems that the Department observed in the early years with respect to the licensees or I should say applicants for licensure that came from the Knox-Mills Act. In those particular corporations those companies we are now seeing comparable problems on the medical group, the IPA, and the limited licensee level inasmuch as much of the risk that heretofore was assumed and retained by health plans has over a period of years been placed at the medical group or the IPA or limited licensee level which, of course, is consistent with the legislative intent of the Act; but, nevertheless, requires a great deal of sophisticated vigilance to be able to manage.

Mr. Chairman, thank you very much.

MR. ENTHOVEN: Thank you, Mr. Barnes.

Mr. Bishop.

MR. BISHOP: Well, Dr. Romero has given me an impossible task of trying to summarize in a meaningful way the Knox-Keene Act. But I think that there's some key points and some themes that are important for this Task Force to understand and to be familiar with.

The Act itself is found in the Health and Safety Code; it has over 250 individual sections and it's

organized into 19 different articles. It's a pretty long Act. It covers over 200 typewritten pages. I think one of the keys to understanding the Knox-Keene Act generally can be found in one of the very first few sections, which is a statement of legislative intent. And I'm going to focus on just four of the expressed intent of the legislature because they're very important, I think, to the philosophy at least to the Department's regulation and interpretation of the Act.

First, the legislature said that one of the purposes of the Act was to assure the continued role of the professional as the determiner of the patient's health care needs. Secondly, they said they wanted to help ensure that the best possible health care be available to the public for the lowest possible cost by transferring, and I think this is rather interesting, by transferring the financial risk of health care from patients to the providers. Thirdly, they wanted to assure the financial stability of plans, and Warren Barnes spoke about some of the early concerns with that. And finally was a broad purpose of assuring that enrollees receive available and accessible health care services rendered in a manner providing for continuity of care.

As I said at our first meeting, the Act applies to health care service plans and that's a concept I think some people have in earlier discussions wondered where the line is between insurance and health care service plans. The Act defines a health care service plan

as a person who undertakes to arrange for the provision of health care services or to pay for those services in return for prepaid or periodic charge. So one of the keys in that definition is you have a prepayment or periodic charge associated.

Then I think the second point is that there is a provision in the Act that says the Act does not apply to a person who has a certificate from the insurance commissioner unless that person provides for health care services either directly or through a contract. So I think that's sort of the second touched on. First is periodic or prepaid charge; the second is the provision of medical services either directly or by contract. That's what makes you subject to the Knox-Keene Act in California.

First and foremost the Knox-Keene Act is a licensing statute. You cannot act as a health care service plan in California without a license. In order to get a license from the Department of Corporations you have to file voluminous documents. These documents include your proposed agreements with medical providers, your proposed form of enrollee contracts, your evidences of coverage; you have to demonstrate the -- in the service areas that you propose to go into the capability of your providers and your hospitals. All of this has to be reviewed as well as your financial capability to provide for the services. The application is not something that comes in on a few pages, it comes in by the box load.

The other thing about the license is once you get a license from the Department of Corporations, you can't make any material change to your operations without filing a notice of what we call material modification with the Department in getting that notice of material modification approved by the Department. If it's a minor change, you can do it by a planned amendment. If you want to expand your service area, that would require approval by the Department.

What I compare this to is if you were an automobile company, it would be like if you want to change your design of your cars you would have to come to the Department of Corporations and get the approval. If you wanted to open a new dealership, you would have to come to the Department of Corporations and get the approval. It is a very high level of scrutiny.

The Act itself applies various standards; those standards go to solicitation and advertising, they go to the terms of the planned contracts itself, and they go to more generally the way the plan operates. Warren alluded to some of the problems in some of the early '70s regarding solicitation. The Act has specific prohibitions against deceptive advertising by plan or plan solicitors. The Act requires specific disclosure in terms of evidences of coverage, and there are numerous provisions in the Act that go to very specific topics, like there's specific requirements regarding arbitration provisions or processes for denying services. Also there's disclosure provisions

relating to how the plan operates, its grievance processes, and more recently a disclosure requirement about the Department's toll free hot line number. There are numerous kinds of specific disclosures that have to be made. In addition to the soliciting -- oh, one more point on the advertising. Advertising by plans has to be filed with the Department of Corporations.

In addition to the advertising solicitation standards, there are specific contract standards. The contract that the plan enters into with the purchaser or the enrollee to provide the services. There are just pages and pages of contract standards that are set forth; there's Article 3.1 which deals with numerous requirements that relate to small employer group plan contracts; there's an Article 3.5 of the Act which deals specifically with Medicare supplement contracts.

In addition, there's a general provision in the Act which requires that all contracts with enrollees as well as all contracts with the providers must be fair and reasonable and consistent with the provisions of the Knox-Keene Act.

Thirdly, in addition to the advertising in the specific contract requirements, there are specific standards for the operations of the plan and these -- there's some very general standards which I think collectively represent the heart and soul of the Knox-Keene Act and one in particular I think that is fundamental. I will hit on a few of them.

First, all facility providers and equipment that the plan uses must be dually licensed in California. Second, all services must be made readily available at reasonable times to enrollees. Thirdly, the plan must be able to demonstrate to the Department that it has the organizational and administrative capacity to provide the services that it is contracting to perform. Fourthly -- and this one I think is really the most fundamental and in terms of the philosophy of the Act -- is that the plan must be able to demonstrate that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative concerns.

In addition to these more general requirements, the Act is filled with a lot of very, very detailed requirements relating to all kinds of specific situations. In many cases, I believe the specific requirements are basically footnotes to the more general requirement. For example, there's a provision requiring comprehensive preventive care for children. I think while that's in the Act, I think it's also part of the more general requirement that plans provide basic health care services. There's specific requirements for coverage of osteoporosis, there's specific requirements for prosthetic devices or reconstructive surgery regarding mastectomies. There are a whole lot more of these specific requirements that run for pages and pages in the Act. But what I want -- I think it's important to understand that there's a lot in there in terms of specificity.

I think the Act in addition to being a licensing Act is one that provides for continuous oversight of the plans. The plans are subject to periodic medical surveys which are on-site surveys; those are required to be conducted every three years. The plans are also subject to periodic financial examinations which are required to be done every five years. So there's more or less constant contact.

In addition to these periodic surveys, there are follow-up surveys and what we call non-routine surveys, which are what the Department conducts when they become aware of a potential problem. They may go in and do a non-routine, on-site investigation or survey investigation or survey of the plan or specific aspect plan of the plan's operations.

Finally, the Act provides for broad enforcement powers. We have the authority, the Department of Corporations, to issue administrative cease and desist orders. We have the authority to institute civil injunctive actions; we have the authority to seek appointment of a receiver; we have the authority to seize the business; we have the authority to seize or to freeze new enrollment; and we have the authority to issue civil penalties.

The thought that I would like you to be left with is that there is a lot in the Act now both in terms of specificity but also some very important and broad general principals both in the legislative intent and in

these general standards that apply to plan operations. It's a very comprehensive Act. It's not necessarily the best drafted act because it's been added to, and sort of like a house that's built without a plan, but there's a lot there and I really encourage people who are considering Knox-Keene Act regulation become familiar with the way the Act operates, the philosophy of the Act, what is required of plans now.

MR. ENTHOVEN: Thank you very much. We did ask that a copy of the Knox-Keene Act be sent to every member of the Task Force and I trust you all have it and are working your way through it diligently.

Are there questions from the Task Force?

MR. ZAREMBERG: I think the charge of the commission was to look at who should provide oversight governs, not necessarily whether we should amend the Knox-Keen Act, maybe Commissioner could talk to us and discuss with us the implementation of the Act. How you see you do your job? For example, on the issue of medical decisions is there -- how do you process that or are there issues there? I mean there's things in the Act but how do you implement those? And I guess finally you've received I think a large budget augmentation, how do you see that being utilized and how would that be addressed in the future and what would that be used for? I think that's important to our charge here.

MR. BISHOP: I would characterize Knox-Keene Act as particularly with a plan of any size of almost

continuous contact between the plan and the Department and the contact comes about in a variety of different ways.

As I said the Act requires that any material change in the operations. It's rather extraordinary if you want to expand your business normally you don't go to the State and get permission. If you want to change a contract term normally you don't file your contracts with the State. So there's this avenue of material modification plan amendment contract process in advertising that we get filings all the time.

The medical survey process is a point of constant contact as is the financial examination and it's the medical survey is just a flavor of it. There's an on-site portion, but once that is done then the preliminary report is delivered to the plan and there's -- the plan has a chance to respond and that is a process of interaction.

There's also the complaint process. We have had for some time in consumer services unit starting in October of '95 we inaugurated the 1-800 number. So that is a point in which we're handling individual complaints that come in to the Department. When we get a complaint we contact the plan to get both medical information, if medical issues are involved, and the plan's at least position on the complainant. Those complaints then they go through their process but they also dove tail into our on-site survey processor point of data for that process or may be flipped over into an enforcement proceeding.

That's the other area of contact is through our enforcement processes, we may be doing an investigation or actually engaged in litigation with the plan.

In terms of the augmentation --

MR. HAUCK: Keith, before you go on with that, before you got the augmentation, given the extent of the Department's potential contact with the plans, were you actually able to perform on the mandate of the law?

MR. BISHOP: We were basically in a triage situation in terms of trying to fight the hottest fires and the augmentation was something we began looking at last December; Gary Haggin (phonetic) is the assistant commissioner for the health plan division. What I wanted to have done was basically a performance review. Look at all sectors of our activities, what we required to do statutorily, whether we were -- what our backlog was, whether we were meeting our statutory performance standards or an internal performance standard, and if it weren't what it would take to get there. So that was the genesis of the augmentation that we requested. The augmentation --

MR. HAUCK: The answer was you weren't sufficient?

MR. BISHOP: In many areas we were behind.

MR. ENTHOVEN: Jeanne.

MS. FINBERG: I wander if you can comment on the separation of the regulation of the PPOs and then also

on the overlap in your oversight responsibilities and quality measurement with the Department of Health Services. So in other words the Department of Insurance's part and the Department of Health Services' part.

MR. BISHOP: I'll give you a general answer and Warren is the master of this issue but basically the fundamental dividing line, as I said, there's two parts to being a health plan prepaid or periodic charge, and the other is basically the provision of services. And normally a PPO, which would not be regulated by us, would fail one of those two tests, usually it's the test of the prepaid or periodic charge.

MS. FINBERG: Maybe I should clarify my question. I didn't really mean what it is now because I know what it is but whether you think it should stay like that if it isn't working with those lines. Because as you know there's several proposals to change that and I wondered what your view of those changes would be.

MR. BISHOP: I view that as a fundamental difference between insurance and health care service plans and basically the difference is within an insurance company basically they're indemnifying you against a loss that you may incur. In the case of health care it's not a health care cost. You don't hold the insurance company accountable under indemnity insurance for the providers -- the job the provider does. The old system, if you had health insurance, you would choose your doctor, if your doctor did a bad job you would go after them for

malpractice.

The nature of the obligation with the health care service plan in my mind is fundamentally different which is that they both take the risk of health care costs but they also undertake the obligation to provide or arrange for the provision of health care services. And so insurance regulation is directed mainly at ensuring that one the insurance companies have the financial capability to meet the obligations; and, secondly, that they're honoring their contracts.

Our job is a lot more complicated because the contract performance in insurance is paying the money. Our job is that to ensure that they're providing the quality of care and the services that they are obligated to provide. So it's a very different, I think, kind of regulation. It's much heavier regulation under the Knox-Keene Act than under the Insurance Code because there are a lot of things we look at that there would be no reason to look at in a pure indemnity insurance environment.

MS. FINBERG: So you see a fine line between the provider organizations and the HMOs, and if you had, for example, a health service plan with a point of service option so you're getting in to some sort of mixed animal you still see it would be appropriate to have them regulated separately?

MR. BISHOP: I think that, you know, fundamentally the health care service plans they're

offering a different product, which is a service, it's not a promise to pay money and that's what really distinguishes the Knox-Keene Act regulation.

MS. FINBERG: And then the quality side, the other part of the question was the oversight with regard to quality that your agency has and shares at least for some plans with the Department of Health Services.

MR. BISHOP: We do share -- there is an overlap. The Department of Health Services contracts on behalf of the Medi-Cal beneficiaries a plan that we license and are responsible for may have a lot bigger enrollee base than the medical beneficiaries. So our responsibility is broader to the extent that there are commercial enrollees. In most of these plans there are, and we would look at protecting all the enrollees of the plan making sure the plan meets all the obligations of the Knox-Keene Act where -- and I will let Kim Belshe' speak for her regulations, but at least my understanding of it is that they're primarily looking to see that the Medi-Cal regulations and statutes are complied with for the protection of the Medi-Cal beneficiaries.

MR. ENTHOVEN: Mark Hiepler and then John.

MR. HIEPLER: Question to both Mr. Barnes and Mr. Bishop.

I represent a lot of patients who are denied care they believe they're entitled to as well as physicians and groups on the business issues whether or not they're reimbursed, and from our perspective, the

patient perspective, they see their HMO is the local medical group, the local management company, that agrees or disagrees with their doctor's decisions and judgments. And more and more it seems as if the HMOs are delegating their duties and responsibilities to these IPAs as Mr. Barnes spoke of. What existing oversight is there, other than through the top of the HMO, to make sure they have a contract in place with an IPA to actually regulate who really is doing the bulk of managed care right now the IPAs, the medical groups. Is there any angle right now existing to really make sure that those IPAs are fulfilling the responsibilities of the Knox-Keene Act to make sure that finances aren't the first issue before health care and rather the other way around?

MR. BISHOP: I guess there is at least two answers to that. From our perspective we hold the plan, the plan is our licensees and we hold the plan accountable whether they choose to use contractors or not they're accountable for the performance and for complying with the Act. And that was illustrated I think best in the case of Carla Christie (phonetic) which is where we find take care of $500,000. Initially the decision was made at the group level and the plan at least wanted to defend itself by saying that's not us. But we hold the plan accountable for the act, in compliance with the Act.

Secondly, there has been at some of these groups and organizations have gotten bigger. We have issued limited licenses to some of them and once they come

under our license then they are subject to the provisions of the Act and to enforcement by us.

Warren, is there anything you would --

MR. BARNES: I might augment briefly that you're quite correct that the action today from the consumer perspective and certainly the consumer's expectations are focused more on the medical group or IPA than the health plan, and research may or may not show that the real critical variable is the fact that the medical group and in specific the primary care physician, assuming the plan uses a gatekeeper model as the vast majority do.

Commissioner Bishop said that the plans are responsible. They're responsible in two primarily ways. First of all is to assure that the medical group or IPA has the fiscal and administrative capacity to do the job that the Department requires the plan contract or provider contract between the plan and provider group to obligate the provider group to do. Plan has complete oversight on that side of it. Also as Commissioner Bishop indicated complete oversight on quality of care defined broadly to include everything that a consumer would need insofar as meeting completely the requirement that medically necessary services be provided when necessary not when the plan would like to balance that out against other considerations.

Although, again, the question shows the awareness that balancing out medical necessity against

other considerations more frequently now is happening at the medical group or IPA level inasmuch as the vast majority of them are capitated at least for physician and related services, the limited licenses that Commissioner Bishop alluded to are typically sought and provided once demonstration of compliance has occurred. In a situation where either a management company rather than the medical group itself in fact is operating as a plan within the definition of 1345 (f) or where the medical group or IPA is responsible not only for professional but for also institutional services or vice versa. That is where the action is and it's the interplay, the tension between financial incentives of all types and the market moving rapidly therefore financial incentives are evolving rapidly. It's the tension between the financial incentives on the one hand and quality of care, the Hippocratic Oath assuring that services are provided when they're need and that they're medically appropriate enough to the standard of care. That is where the action is today. It's much more finely tuned, it's much more complex now than it used to be. But in very generic terms that's where the action has always been although historically it's been much less action there.

MR. HIEPLER: You guys sit in a very unique position. Do you feel that there should be more direct regulation, I guess for lack of a better word, of the IPA level or do you feel that you can control them significantly by looking at the big player, the HMO, and

having them work down?

MR. BARNES: With the promise of staffing sufficient to bring us to what I would consider to be an adequate level, there is I think a very high likelihood. I have the expectation and I believe it's realistic that under the existing regulatory scheme we will be able to provide that. That presupposes two invaluable sources of current information that Commissioner Bishop alluded to earlier and one is consumer complaints.

The more we get the 800 number in the public mind and the more we hear from consumers the more we're able to identify where there are problems. And the very same thing is true of providers, even though the Department has no authority to require proper resolution of provider complaints. Nevertheless, it is true to the extent that providers can be induced to provide information regarding a problem. We do get information in plain manila envelopes. It sometimes helps the Department because it helps us to know where to look.

The problem with that is frequently consumers may lack the sophistication to define the problem to understand where they are, how they arose, and what can be done with them. On the consumer side -- and frequently the problem with that on the provider side is now that the providers are largely being incentivized to have what some consumer advocates consider to be an inherent conflict -- medical necessity on the hand verses financial incentives not to provide care on the other

hand. It isn't normal to expect physicians or other health care providers to relate to that ethical dilemma by corresponding with the regulator.

MR. ZATKIN: Now --

MR. ENTHOVEN: I have a list I'll you put on the list. We've got John Perez, Bruce Spurlock, Peter Lee, Bernard Alpert, and Rodrigues-Trias and I'm seeing there are time horizons so I'll put on the list and we'll cap the list here, okay.

MR. PEREZ: I wanted to get back to Mr. Hauck's questions. What deficiencies specifically did you identify prior to requesting the augmentation?

MR. BISHOP: They were specifically identified in the augmentation, but they ranged from timely processing of the notices in the June modification. Under the statute, we're supposed to process those within 20 days and we weren't meeting that goal. It was just a list of many of the things like that that the consumer services unit -- one of the things that I've been very focused on in the last year is speeding up the time of response to consumer complaints and what we found is that we had, at least a year ago when I came on board, a very large lack of medical consultants and we've increased in the last year within existing resources the number of medical consultants by 700 percent available to the Department. We need more both from -- the just having the number of consultants but also we have to cover a range of specialists. We can't have one doctor. We need

opthalmologists, dentists, OB/GYN, internist --

MR. HAUCK: What are the numbers?

MR. BISHOP: Seven to over 50.

MR. ENTHOVEN: Of medical consultants?

MR. BISHOP: Yeah.

MR. BARNES: Physician.

MR. PEREZ. How far are you now from being closer to what you think is optimal running in terms of making some of these changes and what are some of the financial constraints that may be impeding some of that progress?

MR. BISHOP: We don't have the augmentation yet, so we have no -- people have been hearing about the augmentation assuming that we actually have the money. We don't have the money; the budget has not passed yet. When it is passed, then we will get the money and we will have to staff up accordingly. So right now we're operating under the budget that I got a year ago; we'll do that until June 30th or until there's a new budget.

MR. PEREZ: But given the augmentation that you expect, how close do you expect to be within a years' time frame?

MR. BISHOP: Based on our performance that's what we think we need. And we did a performance analysis of all areas including the enforcement area and in our budget augmentation request we requested a doubling of our enforcement council.

MR. ENTHOVEN: Thank you.

Bruce.

DR. SPURLOCK: I want to go back to what Mr. Zaremberg was addressing earlier on when he talked about financial influence on the decision-making process --

THE REPORTER: Excuse me, could you slow down a little, please.

DR. SPURLOCK: Okay. We all understand the complexity of the physician compensation issue and how difficult that is. I'm curious what activities and what methods -- I'll get that out one of these times -- that you used to deal with that issue of undue financial pressure on the decision maker and in this world of outcome what kind of outcome can be measured? We know HICFA is now asking medical groups to display their compensation and bonus processes. Is that the type of thing that you do or how do you look at that and what are the outcomes of those ethics?

MR. BISHOP: One of the frustrations for me and the whole managed care field is there's sort of a historical amnesia that the debate seems to start with the advent of managed care and looks at everything as if there was no history. And I think the history is that there have always have been conflict of interests inherent with physicians. There were different conflicts of interests but they existed and they existed under the old fee for service because there it was clearly an incentive or potential incentive for the physician; the more he did the

more he billed. And there was also financial incentives related to referrals to medical clinics and drug labs and things like that that led to federal legislation with very severe criminal sanctions. Pete Stark (phonetic) authored that and there was quite a backlash about those incentives.

So we're not operating in an environment in which there won't be incentives. Every system will have economic incentive, and I think that's important to remember as we look at this it's not just to look at managed care regulations in isolation as if there was no history. I don't know that there's a system that won't put the professional and everybody in the system, you know, totally free of economic incentives.

We do -- there are specific provisions in the Knox-Keene Act that prohibit, you know, payments for denying care, and I can let Warren get into the specifics of those if we can talk about that.

MR. BARNES: The failure to provide medically necessary care, as we all know, is prohibited on the part of a plan and consequently on the part of the contracting providers. I think the Department is acutely aware of the need for fine tuning in the tension between fiscal incentives and quality of care and measurement of quality of care and we're doing this in part through upgrading the caliber of the people who are doing our work.

For example, we now have a doctor of nursing

who is the person primarily responsible for handling merchant complaints who has a greater ability to spot and deal with those issues than would, for example, a regular R.N. By contrast, at the same time incentives are very rapidly evolving. Today's incentives may or may not be tomorrow's incentives. It's almost that rapid.

One of the geniuses of AB 138 when it was enacted in 1975 was to provide, for the most part, general regulatory provisions that afforded the regulator a great deal of flexibility to enable plans to keep up with the marketplace but at the same time provide necessary consumer protections, and the action now is with financial incentives and quality of care, measurement of quality car. One issue, obviously, is a sense the vast majority of providers are now capitated the amount of capitation payments. All provider compensation by law under the Knox-Keene Act capitation or otherwise incentives or not is all confidential. I have seen some eyebrows raised on the staff level of some of the capitation payment. Services have to be provided. Providers have to be compensated. It's very difficult; it takes the wisdom of Job to regulate that situation the way which doesn't impede legitimate business at the same time which allows providers to receive what they need to receive so that consumers can receive what they need to receive.

DR. SPURLOCK: So you see all the capitation contracts, do you, is that what you stated?

MR. BARNES: We see all compensation

arrangements with physicians who contract with plans or medical groups or IPA who contract with the plans. We may or may not see the financial arrangements that a particular medical group or IPA has with a particular physician member of that group or IPA.

MR. ENTHOVEN: Let me butt in for a minute. This is an excellent discussion and I hate to curtail it but I also am concerned about the clock so I would like to see if we can move through the others very quickly. There are very interesting points.

Peter.

MR. LEE: Two questions. One is I want to come back to Jeanne's question, the question about the audits, but I understand the different functions of the DHS and DOC, the question was specifically in terms of having multiple similar functions happening like medical audits. I would like to know what the Department's doing currently in terms of streamlining auditing of health plans, medical groups between not DHS but also private sector, that's one.

The other question is specifically related to complaint data, are you currently collecting or tracking complaint data by medical groups and to your knowledge is that one of the major things we need to be looking at is those frontline providers. Because I know it's not reflected in the report here, the new report, but are you collecting and analyzing data by provider group?

MR. BARNES: In terms of in coordination

with DHS and others on quality assurance, the private organizations like Nick (phonetic) that are reviewing for quality, we take that into consideration. But our reviews are in many ways different and I think in some ways at least certainly preferable from the consumer perspective we go to provider offices; we review consumer charts. We look in those areas where our experience tells our professionals there are most likely to be problems, but we take all of that into consideration. We obviously contract with highly qualified professionals to conduct all of our surveys either on an out-source basis, as is in the case with full service, or to augment our full-time staff with regard to other plans.

The evolution of a corporation with DHS has occurred over a period of years. DHS tends to track the service, the services that are received for the dollars that are paid as a generalization, and the Department of Corporations has more of a systems wide audit based on assuring compliance with the system to primarily the Knox-Keene Act but at the same time, as I indicated, delving into where problems may be found. Over a period years we've done some things with DHS, they have done some things for us, we've done some things for them; sometimes we've gone out together. Sometimes plans have squealed, there are too many people, get the hell -- I'm sorry, get out of here, there were too many of you. And sometimes we adopt their report. But in general my perception is that the current relationship with DHS is quite cordial. It's

impossible to cooperate with anyone in a basis that is fully satisfactory to everyone in the industry.

MR. LEE: Next question on medical groups and complaint data.

THE REPORTER: Excuse me, my machine has been blinking at me for an hour, I'm going to run out on my battery. Can we take five minutes, please.

MR. ENTHOVEN: Sure. Five minute reporter break.

(Recess.)

MR. ENTHOVEN: The next question will be asked by Dr. Helen Rodrigues-Trias.

MR. LEE: I object, your Honor.

MR. ENTHOVEN: Oh, sorry.

MR. LEE: I had a follow-up question that was about to be respond to.

MR. ENTHOVEN: Excuse me, I'm sorry.

MR. LEE: You still get to go next, I was not objecting to your perspective.

(Whereupon numerous council members spoke at once.)

MR. BARNES: The chairman has been inducing me to be brief.

The Department is very cognizant of which medical groups and which physicians account for complaints, but the answer to your question is no we do not compile that data. That -- compiling the data in a formal way we do not do, but we are aware of it with our

complaint process, and we are cognizant of it and we combine the complaint process merge it into some extent the medical survey process to accommodate those kinds of issues. Actually collecting the data in a formal way and a statistical way is an example of scores of things that the Department would like to be able to do which it hasn't had the resources historically to do.

MR. LEE: Which you would be able to do with your augmentation?

MR. BARNES: I would anticipate that this would be among those things we would be able to do, but please bear in mind it would be confidential information. It would not be anything we would be in a position to publish under current law.

MR. ENTHOVEN: Helen.

DR. RODRIGUES-TRIAS: We received some information on the medical managed care quality initiative which I understand you're a part of the group that's working on that, and I wandered if you could comment on what implications this may have in terms of the cost of doing the quality insurance vis-a-vis in order for the system from getting -- but also into moving into more outcomes type evaluation.

MR. BISHOP: In terms of quality care I think you raised a very good point which is at least the way I think we should -- the debate has been processes outcome. The way I see it is quality care should be a function of both the procedures and the cost and in a

very -- I also think it should not be a static measure with where you take a snapshot at one point in time. A person's life is like a movie, it continues. You just don't have a procedure and that's the end of everything. I think we should ultimately be looking at a definition of quality of care that is a function of the change in health status which is the change in cost, the expenditures, and that is a view that I would encourage the Task Force to put back in the cost element of this function. And it's actually, you know, in the -- when I was talking about the intent of the act they were talking about assuring the best possible health care at the lowest possible cost and I think that captures what I think is really important.

MR. ENTHOVEN: Brief comment by Dr. Alpert.

DR. ALPERT: I want to thank Mr. Bishop and Mr. Barnes for clarifying for the first time for me where the root of the entire problem is that we've been grappling here, i.e., the incentives, the quality, the cost and so forth. I didn't realize the root was right in this act codified.

You started by quoting, picking four points and then elaborated, I think it was four others, and the one you just talked about, again, is helping to assure the best possible health care cost for public at the lowest possible cost by transferring financial risk from patients to providers as opposed to the next point which says an oversight on quality of care, care must be given by qualified medical providers unhindered by fiscal concerns.

Those are incompatible statements both contained in the Act, and to me codify the root of our entire problem and perhaps we should point that out in a summary as we begin to say wherever we are going to go.

MR. BISHOP: I would say again I think those are both very important that's why I mentioned them. One is the intent of the legislature; the other is the actual legal standards the plans have to meet.

I don't think any system will ever be free of economic incentives on providers or the plans or any other participant on the health care delivery system. There were will be incentives. The assumption with regard to the discussion this morning is there's an incentive to provide less care. There are arguments that there are incentives to provide preventive care and minimize cost to the plan by reducing the -- by forestalling big plan cost by low cost preventive measures.

So although the discussion has been sort of this morning that there's always the incentive to provide less, there may actually be incentives within this system to provide preventive and other care which lowers the cost of health care for the clients.

MR. ENTHOVEN: It's a good question we need to discuss more. On the face of it there's quite a bit, so thank you for raising it, but let's be sure to revisit that.

MR. HARTSHORN: I wanted to respond and we can perhaps go up another level because the HMO Act, the

federal act in 1975 has -- I don't think it's exactly the same but that started the process for lots of states to start changing their regulatory process for HMOs. So we have to look at also -- I mean not that it's our responsibility but to start at a federal level as well.

MR. ZAREMBERG: I think it's important. I think we should discuss this further and I appreciate what Dr. Alpert said, but I think there's another way of looking at it rather than saying they're inconsistent and one is a statement and one is a qualification of that statement and one is a goal and it's qualified. How you do it and ensure that you don't inhibit your ability to medical decisions or are inhibited by financial incentives or in making sure more people have health care I don't think is inconsistent with that qualification. So I think it's worthy of further discussion but I think it's important to point that out that it may be apparently inconsistent but I'm not convinced it is.

MR. ENTHOVEN: Well, and we have to recognize the inevitability of cost containment, that is we can't go up to 20 or 30 percent of the GNP spent on health care. So somewhere, somehow people are going to have to make value for money tradeoffs, and it can be a real problem as our society comes to terms with that and recognizes it.

I think we're going to have to stop now and move to the next. Thank you very much.

MS. SINGH: Steve Zatkin --

MR. ZATKIN: I told Allan my question already and it had been asked by Bruce on financial.

MR. ENTHOVEN: Now we're going to have Ellen Severoni is going to lead the discussion on consumer information and involvement. She is the executive director of California Health Decisions and then she'll be followed by Ms. Jeanne Finberg from the Consumers Union who will comment on that and put forward some of her ideas on consumer involvement and information.

We'll start with Ellen up here.

MS. SEVERONI: We're going to be using slides so they'll be projecting right up here for you. I've heard enough jabs about the fact that these definitely look like they're from Southern California. Spain is the name of the program on the computer so that's why.

Anyway, thank you very much. I'm going to move as quickly as I can through three different points that all evolve around in involving the public around health care choices. Each of you has a packet at your place that has copies of these slides which will allow me to move through more quickly because I know you'll be able to look back and reflect at a later point.

I'm going to very briefly give you a bit of sense about California Health Decisions and our work involving the public and some of the starting points for the public when we talk about health care. Then I am going to talk briefly about the Medi-Cal member advisory

committee that CHD organized for the CalOPTIMA program in Orange, and at that point I will introduce a guest that we have, Estella Martinez, from the CalOPTIMA program in Orange. She is the staff person responsible for the work of that committee. It has been two years since I have been there, so she can tell us how this consumer-involvement model is working.

And then thirdly, I will be discussing what are called consumer feedback loops which are very recent projects that CHD has created with the help of several health plans, large medical groups and large employers in this state that bring enrollees directly to the table in determining how the system will recreate itself and improve itself.

So we have been around since 1985 and our mission has never changed. We are committed to educating and involving the public in issues relevant to individual and societal health choices; to assure that community values are incorporated into health policy.

Since our beginnings over 80,000 Californians have participated in our activities and programs. Most of those people have sat in town hall meetings, like the one we are sitting in today, as a way of participating in small group meetings as well as in focus group research.

I would like to say within the first ten years of our existence, we would point out that there are five areas that we consistently find that experts like

yourselves and the public perceive in very different ways; first would be cost. Most ordinary people think about what they spend out of pocket, so every time an article appears talking about how cost of health care has gone down as a result of managed care, most people are thinking about the fact they're paying more now in co-pays, being asked to make more tradeoffs. So we don't start the same place.

In terms of coverage, people really don't clearly understand who is and who is not covered and we all know that how we do that in our society does drive the costs of care.

In the next area waste, fraud, and abuse. The public thinks this is the cause of rising cost and why they're being asked to make more difficult tradeoffs. Just thinking last week, what were headlines, 23 billion dollars in inappropriate payments in the Medicare program. For whatever reason these are issues that continue to plague us.

The next two areas both technology and aging. Those are areas where there's very little understanding at all in terms of how technology, for instance, drives the cost of care and the aggregate. People see that more clearly, more duplication part of the greed issue. Most people tell me Ellen it's Economics 101. I bought a VCR 15 years ago it cost well over $1,000. Buy one today it's several hundred dollars. Technology makes things cheaper.

In terms of aging, this does not seem to be lost on people but in our experience at CHD resisted. People who have self-selected, and most of them have, come out to our meetings are 45 or older and it's very difficult to get them to think about their parents and others who are looking at having maybe more limited choices and thinking about needing the tradeoff; that's just a starting point.

We've found you can either throw your arms up and say there's no way to close those gaps with education, or you can change the way you hold conversations with the public to be focused in on values. And over the years of our work we have found that these seven values, and I have mentioned them in previous meetings, are used over and over again by the public when they think about and talk about health care choices and making tradeoffs. And I would suggest that these are the kinds of values that most of our organizations pose as important to us when we think about how we are going to provide service to the public. So I think there's quite a large common ground here.

Values drive decisions and I'm going to focus today mostly on the first folic and last folic. First in terms of defining quality, which is something I believe the experts and the public must do together if in the coming decades we are going to be able to agree upon what quality is and have consumers be able to use that as a tool to move from provider to provider and from plan to

plan, and I think maybe we better, instead of having someone coming from the foundation for accountability back to talk with us about the work they're doing in putting quality information into the hands of consumers.

Certainly in choosing a plan or a physician values are important in deciding on treatment options, considering end-of-life choices. Just as an aside we've done workshops for 50,000 people here in California on how to complete advanced directives. In an evaluation we found that two-thirds of the people who come to our workshops go on to complete advanced directives. It's very a high record, and again we use values as opposed to talking about treatment options.

And then on values to evaluate health reform, and that's going to move me to the very first consumer involvement model that I would like to talk with you about.

One of CHD's concerns was that mostly white women 45 or older and with middle or upper-middle incomes was most of those 80,000 people were coming out to our programs. We decided in 1993, when it became clear that the Department of Health Services and the State of California was going to be moving more Medicaid members into managed care, CHD decided we were going to go out and talk to Medi-Cal members. And especially with our offices there in Orange, it was important Orange County was going to develop a county organized health system for just under 300,000 members.

Our goal was to develop a replicable model by which the Medi-Cal members, the beneficiaries values and needs could be incorporated through their direct participation into all phases of local organized Medicaid manage care systems. Forgive me, I do this slide on a national, these programs nationally so I switch back and forth between Medicaid and Medi-Cal slides often.

Now when I showed you those set -- that set of values, you have in your packets an executive summary of some focus group research we did in 1993 with Medi-Cal beneficiaries. I would like to encourage you to either visit our web site to download this 50-page document of that research or certainly contact CHD and we'll mail you the full report, which I have in my hands here. But just to give you a sense that when we moved to working more closely with Medicaid population, what we found is people use the same values, it doesn't matter who your insurance plan is, you're use the same values to make decisions but the priorities are different. And this population focused much more on the issues of being treated fairly and with dignity and respect. The cross section looking much more at affordablity and personal responsibility with both groups very concerned about quality and accountability.

When I use the word accountability, just to generalize, we're talking about where people are able within the system to find that person, that body who can help them either navigate their way through or resolve a problem. So the difference between person and

responsibility and accountability is the accountability value is very clearly related to systems.

I was a member of the board of supervisors task force on health care and when the county decided it was going to set up a county organized health system for our 300,000 beneficiaries, I was fortunate enough to have the board appoint me to chair a member advisory committee. They asked Dr. Camerman (phonetic), the president of the Medical Association, to chair the provider advisory committee and the county health care agency served as the government body that help spearhead the move.

I've come back to this point many, many times. The member advisory committee existed before CalOPTIMA, before the board of directors, before the CEO existed. And that had a lot to do with how integrated this member advisory committee is. We used the research that I have discussed briefly to ground the member advisory committee in its policies and practices. So we used the beneficiary's research.

I have never been on the Medicaid program so feeling that I could chair a committee like this would have been very difficult if we hadn't talked specifically with beneficiaries. Although I will share with you that I have two sisters on the East Coast who have both used this program to provide health care for them and their families.

The member advisory committee worked very formally with the provider committee in designing the

implementation of CalOPTIMAs mission, structure, and goals, and many of those documents are available to the Task Force in formally looking at the CalOPTIMA program there in Orange. That meant we were even participating in deciding the number of board members for CalOPTIMA and where those board members would come from. So it was a wonderful day when that board was together and it adopted our admission which was to ensure that members values and needs are integrated into the design, implementation, operation, and evaluation of CalOPTIMA.

I still think in my experience, and I have been a nurse since 1971, that this mission statement is revolutionary in many ways. I think while we have some intent to involve members to clearly make it part of the mission of the organization and even the operation of evaluation, it's not something that I see in most organizations.

The board adopted our goals, which were to communicate and advocate for members' needs, and the structure of this committee answers directly to the board of directors of CalOPTIMA. This committee is not placed in a member services department or somewhere far away from the power structure. It serves directly under the board of directors and answers to the CEO, the CEO attends almost every monthly meeting. This committee serves as resource to the board and to the staff. Its goal is to reflect community diversity and to communicate CalOPTIMAs role in creating a healthier community.

When we organized this committee it was very important to members of the CalOPTIMA member advisory committee that some day this organization not only serve Medi-Cal patients, but it also serve the indigent in Orange County, and I know since I've left that's been more of a focus of the organization.

As I say just to give you some examples and evaluation if you look at the mission and goals you will see the very values that are identified in this research incorporated clearly into the mission and goals. Our organization participated in the recruitment of the CEO and setting the marketing guidelines in all of the member orientation information, even though at times it meant slowing down bureaucracy because materials were created to go out to the beneficiaries and once our committee got at it they required many, many, many changes. But we found that even though all of our work slowed things down, in the end most things were much, much improved. We were even involved in helping to design the provider contracting structure as well as looking at and participating in continuous quality improvement actives.

My hope is, as the system is only up since October of '95, that as we move forward we will be able to see that we were able to decrease the costs of care from Medi-Cal beneficiaries in Orange County; that we're able to improve quality of care to provide more choices and to improve access.

Certainly I know, having lived in Orange

since 1979, that there are definitely more choices of those 300,000 beneficiaries. Before CalOPTIMA only 50 percent at any given time of those people had access to needed medical care. I remember sitting in rooms with ten or more pregnant women who were dialing for doctors, looking for physicians who would serve this population. So even though we had the card people didn't have access.

And then finally before I move on to this next consumer feedback loop, I did want to say that one of the things that the chairman asked me to do is to think about, oh, incentives, regulation, and the kinds of things that this Task Force is looking at. And I did want to say that one of the things that made this work is that the James Irvine Foundation provided a grant to California Health Physicians so I could volunteer my time in creating and working on this member advisory committee, that I could hire staff. And I think as we are looking at the other Medi-Cal systems throughout the state we really have to consider that this was a very labor intensive process; the amount of reorganizing that went here, and I think looking for putting some dollars into this whether private or public is very important.

Estella Martinez is here and before I move onto this next section I thought if you have some questions for Estella about this particular program I would stop here before I move on to the consumer feedback group.

Alain, would you like me to do that or do

you want to barrel through and put the lights back on and have questions for everyone.

MR. ENTHOVEN: I'm worried about the time element. I wish we had more time.

MS. SEVERONI: Okay. So barrel through.

So I will come on down. Let me go back here and say -- all right.

Now we are talking about the consumer feedback loop. This is a model for improving health care quality that involves patients, providers, purchasers, and health plans in a consumer driven process of research, solutions, change, and evaluation. This is what it looks like. You will see this figure as it goes through again and again. I think you'll note with me that the missing link to this point has always been putting the employee and the patient, I think, at the same table with the other decision makers as we're looking at system changes.

And we'll move very quickly to say in each of these projects, that I'll just barely highlight, each project requires that a team be organized, that a mission vision guiding principals and goals be agreed upon and resources be committed.

There are four steps in each one of these projects. The first one involves research with both enrollees as well as providers. The second step is once we get that information gathered, we design solutions with the full team. We then implement changes, and the fourth step is to measure and evaluate.

The very first project that was done, these have only been begun as of the last couple of years, was with the St. Joseph Health System was the employer, the Orange Coast Managed Care Services, the Physicians or Medical Group, the St. Joseph Health System, the employer, sorry, the employees and Pacific Health Care Plan. This was the very first project the CEO of the health system came up and said our enrollees are unhappy in managed care, can you take those set values and create an evaluation tool. I said I would be happy to do that but only if he agreed to bring the health plan and the provider group to the table to correct or improve those concerns that the enrollees had because the last thing we need is another market research firm these days telling us more about what's wrong. He agreed to do that; the team came to the table.

There were three key areas that bothered the enrollees: One, they don't really understand the use of the E.R. and are very unhappy with that; secondly, they don't think they get the information they need to choose a primary care physician, they get lots of pictures they don't really get the information that's helpful to them; thirdly, very dissatisfied with the referral process. This team decided they wanted to focus on their referral process; they redesigned that process. You got information about that in your packet if you want to look at some of the specifics, and as part of that we created just a very simple tool for all physicians to use in those

offices on patients that need to be referred, which is it simply tells patients and doctors what are the next steps, whose responsibility is what, helps them more easily through the system.

Now what happened around that time -- and I've got two gentlemen here today who will be happy to answer your questions and expand a little bit on this model, Bo Carter from the Integrated Health Care Association, which is an association of managed care organizations health systems, health plans and employers, came down to visit me and was very interested in that feedback loop and wanted to know whether or not we were interested in replicating it. He came back, met with several members of the board of directors, some of them being people from Chevron, Health Net, and Hill Physicians, and this set of people decided they wanted to recreate this project.

Today we have with us the president or, excuse me, the executive director of Hill Physicians Medical Group; I think you'll want to ask him some questions regarding their involvement.

The purpose was to identify and respond to employee concerns about health care services, to involve those enrollees along with representatives from all of the organizations at a project planning table from the beginning to identify those issues, and those issues turned out, again no surprise, to be an access referrals claims and billing; and to develop process improvements,

four of them, to be exact, and here they are.

This team is broken down into several teams that are looking at, (a) redefining financial criteria for pass through procedures in this organization. This has to do with the authorization process, people are still having difficulty and consumers do not separate the referral and the authorization process. It is all one big nightmare for most people as we make our way through these systems and regardless of how hard the systems are trying they're just still not here.

Second marker is to improve physician staff patient communications with regard to this referrals and authorizations. The third was to enhance communications between the health plan and the employer to the enrollees with regard to authorizations. And finally to entirely remove the enrollee from claims and billing issues as soon as they're identified.

This is one process in the improvement that happened immediately. We're in third phase where you can see some of these things are going to take months of work but both the health plan, which is Health Net here, and Health Physicians agreed immediately to -- when an enrollee calls with a billing problem, to keep that enrollee on the phone until one or both of those intuitions can resolve that. So it will be very interesting to see how what that will mean to a satisfaction.

The industry is getting pretty excited here

because now we've got another one of these loops this time with CalPERS, Health Net, and four provider groups. And I just want to show you this is a state-wide affair because again the four provider groups are once again Hill Physicians Medical Group, and we have someone here, Steve McDermott, Alta Bates (phonetic), Medpartners, and Scripps (phonetic). So this is now a state-wide project.

The interest here, again as I move very quickly, is to stay focused, stay focused on that referral and authorization process and to look now for best practices. This is the first time in a project of this nature that four competing provider groups are coming to the table partnering with a health plan and major purchaser all to focus in on enrollee driven concerns. The Medical Quality Commission has joined us in this effort -- they are an accreditation and education organization -- their interest is in helping to spread and develop the best practices and help us move those across all or as many medical groups as possible in the state.

Finally, and because we're again talking about Medi-Cal managed care, I think I'm most proud of the fact that we've got two health plans that have agreed to come to the table in creating one of these projects, the Alameda Alliance for Health and Blue Cross of California, two competing plans this time agreeing to come to the table with Medi-Cal beneficiaries in Alameda County. Five physician representatives, two hospitals, and the Department of Health Services all focused in again on

beginning with enrollee concerns starting from that point and building as a team. I'll just show you about what this team looks like when we put all these partners down.

Working as a team to evaluate this system, the focus, of course, in enrollment right now is with aid to families with dependent children. We'll be starting actually at the end of this month with our enrollee and physician focus group, and we're looking at addressing the entire process. In other words, we're not focusing only on referral and authorization, the beneficiaries will tell us what they're most concerned about and then the teams will work together to move forward.

Again, back to incentives. Let me say on this Medi-Cal project this is entirely grant funded. Those are the three organizations up there that are providing the dollars to do it. Right now our budget is working around $350,000 over two years to do this work.

On the other projects there's a mixture of pain. On the Chevron project, Dole (phonetic) Physicians, and Health Net are sharing payment for that project. On the CalPERS project CalPERS and Health Net are paying. So I think we may -- if you think these are worth while efforts you may want to again think a little about the packets.

I'm going to put the lights up again. I'm going to say that we're very early on in this work. As you can tell there's been a tremendous response from the industry just in this past year. I mean we've literally

just finished the first model and already have three replications with some requests for more.

Now that the lights are on I would like to introduce my colleagues just again to you. Estella Martinez from CalOPTIMA Program in Orange. Steve McDermott, the executive director of Hill Physicians; and Bo Carter from the Integrated Health Care Association, executive director. Just a quick reminder that is the association that brought us up to its board of directors and said what do you think about this and has essentially helped us get the other projects going, open it up.

I hope I did that quickly.

MR. ENTHOVEN: That's terrific, that was extremely interesting. I can see many excellent elements in there including it's continuous quality improvement and how that ties in sort of model which is very valuable. And also it gets people involved in resolving the system design issues at the local level, which is the best place for it to happen. So I think this is wonderful.

I'm being brutally oppressed by the clock. So before we go into questions with your panel, I would like to call on Jeanne Finberg and then we'll have a question and answer general discussion.

MS. FINBERG: Hi, I'm Jeanne Finberg, I work for Consumers Union, which is the nonprofit publisher for Consumer Reports magazine. I'm passing around some things which there's plenty of copies that will be available for the public too which I'll distribute when I'm done.

Consumers Union has been testing products and informing consumers for its 60 year history, and since the very beginning of the organization we have been interested in transmitting information about health. Our very first issue was on milk and on health hazards with milk.

I work at the West Coast regional office, which is based in San Francisco, and it's an advocacy office so we perform the protect function to advocate inform and protect consumers about issues and, of course, the organization has been involved in health reform issues for many, many years, 30 years, and the West Coast office has focused on managed care issues in particular as the market has switched so rapidly to managed care in California.

In terms of consumer -- and I'm going to talk about two things, but I'll be very brief, and the reason I'm passing so much paper is for you to take home so you can read it later. In terms of consumer involvement, we consumers here in the West Coast office of Consumers Union is involved in a project right now involving the Medi-Cal managed care program in California, the two plan model which is in existence in the twelve counties. We are working with the consumer representatives which -- who are supposed to sit on advisory boards or committees of both local initiatives, the county run system, and the mainstream plan, and also consumer advocates that are working with Medi-Cal

beneficiaries organizing, educating, and training those people.

Just to give you one idea of some of the challenges of a project like this with regard to the consumer representatives, we've had a lot of trouble getting a complete list of who the representatives are and some of it is that not all of the plans have appointed or found their consumer representatives yet and so we thought there was a reluctance on the part of some of the local initiatives or the mainstream plans to tell us that they didn't have any. But now I've gotten an official formal response from two local initiatives in Riverside and San Bernardino telling us that they have consumers reps, but they won't tell us the name because it's a violation of confidentiality. I got the same response from Blue Cross, one of the mainstream plans. I think we can work through it; I think they're wrong that the representatives should be known to the other Medi-Cal beneficiaries, but it just gives you a flavor of how difficult it is to work to organize consumer representatives.

I want to focus mainly on consumer information and some of the struggles that we have at Consumer's Union and Consumer Report in obtaining the information we think we need to adequately judge and communicate with health plans, health providers, and to communicate that information to consumers.

I passed around the two Consumer Reports' articles that we published last year on HMOs. The first

one "How Good Is Your Health Plan." You guys have reprints so you don't have the nice color, but if you buy the magazine you can have the color, and then the -- or go to the library, which most people do when they buy a car, apparently. And then the second -- the first was August, the second was in October, and the second issue deals more with some of the financial issues about trends and what's happening with managed care.

We get requests everyday for more information about health plans and about making choices, and we would very much like to issue annual report cards or more detailed information about health plans and we're struggling to try to fulfill that need but we can't do it. We don't have the information that we need that can reliably be used to measure the quality of care and to compare the plans, and we're finding that it's very, very difficult to obtain.

In our surveys, and that's reported in the August issue, we used our annual survey, which we survey our members, which is a good tool but obviously our subscribers of Consumer Reports are not reflective of the general population, it tends to be a more wealthier, more educated and not very diverse population.

And secondly, we use the HEDIS measures, which we got from the plans voluntarily. Some plans actually refused to give us the data, and they were, of course, under no obligation to do that. But most of them did, but just the larger plans participated in the

national basis and we found -- I just wanted to mention although HEDIS is becoming rapidly recognized as the major source of information and important developing instrument for measuring quality, there are some pretty serious limitations on the HEDIS data.

First of all, as a process measure that is available now it doesn't measure quality. If we look at the plans and see which plan gives more mammography screens to its members, it isn't necessarily the basis of choosing a health plan. If I were choosing a health plan I would ask for the mammography screen as opposed to waiting to get a postcard for it. So I wouldn't think of that as a reliable indicator for choosing a health plan. It would be different if they were denying the screen and that goes to utilization, which I'll mention in a minute.

Also the plans are inconsistent in the way that they measure the data and there are inadequate data collection systems making it insufficient information to judge how well the plan serves their members. It's also very expensive. First it was $100,000 cost to participate, so the very small plans don't do that, but beyond the cost to participate is really the cost of collection and that's where the real financial burdens are for the plans and why we need more uniformity. I think it's in hundreds of millions of dollars U.S. health care total; it costs them 300 million to put those computer systems in place.

HEDIS is now collecting utilization data so

we know how many procedures per one thousand enrollees are being done on gallbladder surgery or prostate removal, coronary bypass, but these are not risk adjusted numbers. And so it's information but it is very difficult to use as a measure between the plans.

Additionally, we don't have the benchmarks for what's good. Even if it were risk adjusted, it's very difficult at this point to determine because of the state-of-the-art how many per a thousand gallbladder removals is appropriate for this population. So we're very behind on the state-of-the-art. The enrollee survey can measure some of the issues that are important to consumers that we call the service issues, the waiting times, response to grievances. We can also ask consumers if they get the care that they need, but we find there is a gap between what consumers want or think that they need and what they actually might need or might want to know if it were available to them. Now we're finding most of the surveys are showing that consumers are choosing plans based on cost, primarily based on cost, but it is the only reliable indicator that we're giving them. So I don't think we can conclude that that's the issue of primary interest to consumers.

The plans are very reluctant to reveal utilization data. Our reporters have found it virtually impossible to get that level of information that they need. The industry is very cautious about revealing information that they consider proprietary or a trade

secret. It's not a just general private commercial issue. The health care HMO industry seems to vary from some of the other industries that we have surveyed and evaluated. And a notable example for that would be the long-term care industry which Consumer Reports hasn't been particularly kind to but we found it easier to get the type of information that we could use to measure quality. We think information regarding utilization service and specific disease management are the three areas that would be essential for us to be able to report on plans the way we believe it's necessary.

I mentioned the utilization problems. Specific disease management, there has been some progress in this area, some plans have some particular programs where they're showing good results. They are reluctant to divulge a lot of this information because of selection issues. If a plan shows that they're the best plan for treating HIV, then they will have the sickest most costly patients or similarly for diabetes, etc. So we need to figure out a way to avoid that problem and to get that valuable information for consumers that have a particular condition.

With service issues enrollee surveys, we have not perfected the art there. We found that our data doesn't really match with NCQA's data on enrollee survey and that other report card data is extremely variable on some of those consumer satisfaction issues. And so that concerns us as an indication that we haven't appropriately

developed the measure. There are some major survey enrollee survey efforts ongoing but in addition to NCQA the HICFA, the Health Care Financing Administration, is going to do a big enrollee survey with the federal law and we believe that there should be more consumer involvement in development of those enrollee surveys so they can be a better measure of what we're trying to judge.

A missing piece in consumer information, which was mentioned a couple of times earlier today, is development of information at the medical group and additionally at the physician or primary care provider level. The medical groups mostly, except notably for Kaiser plans, contract with medical groups to provide their care. And in California there are almost three dozen medical groups but there's only about a half dozen or four or five medical groups that all have the big plans views. And if we are -- if many, many important decisions are delegated to the medical group, and if we are measuring quality and we are comparing the health plans that are using the same medical groups, what really are we communicating to consumers? I think we need to breakdown these issues and factors to identify that.

In the third piece of paper that I passed, that I'm sorry you all have to take home with you, is a short paper that I put together at the request of a foundation about some of the issues around primary care. And some of the paper is not relevant to this discussion but it does identify some of these issues about

information that's needed at the medical group level.

At the physician level there is also little information. This isn't necessarily a managed care issue, choosing a doctor and the difficulty of communicating information about physician choice is -- has always been around in the fee for service system and the managed care system but there are certain aspects of the gatekeeper function and the lock-in feature of the managed care that make it even more crucial decision.

We think -- of course there's a lot of information about physicians that would be helpful to consumers to communicate. One of them might be utilization, and one of the issues that consumers are most concerned about is the pressure on physicians to restrict care. And it seems likely that some physicians are less pressured than others, that some are better advocates for the patients than others within the plan in terms of how to manage the system. That's the kind of information that would be very helpful for us to be able to measure and to give to consumers.

We can't test HMOs the way we test cars, although we have been requested to do that, but we can't take testers with various medical conditions and send them off to plans and see what happens to them. So as a result, we need more standardization of information and more cooperation with the plans or required disclosure so that we can do our job disseminating information.

Thank you.

Is that quick enough?

MR. ENTHOVEN: That's excellent, thank you. Thank you very much.

I think that you've made some tremendously important points and I'm sure many of us share your aspiration of where we need to go. I think at least among people I associate with that we share your frustration over the lack of information and can see the long way to go in the future. I think the lack of quality measurement is among other things a legacy from the previous non-accountable system where it's only lately that we've had entities that we can hold responsible that we can say now measure your quality of importance to us as well as the difficulty. Ellen is on the board of the foundation for accountability and they are making progress.

Some of the very important concerns that you raised, Jeanne, the Pacific Business Group on health is addressing such as reaching through to the medical groups, standardization, auditing. We have a California Cooperative HEDIS Initiative, CCHI, and we are asking somebody from PBJ, who is very much involved in these issues, to speak at our July 26th meeting so we'll have a presentation about what they are trying to do. And they're not close to there yet but they are addressing it so I hope you'll participate in that discussion.

What I would like to do is open it to questions and discussions from the Task Force.

Let me say with respect to -- without

objection I propose that we continue this meeting until 1:00 or 1:15 in order to get our work done without cutting this discussion too short, and we can grab a quick bite on our way to the hearing.

Could we start with some of the presenters who have come. Do you have other comments you would like to add? And then we'll have questions and discussion of the Task Force.

MS. MARTINEZ: Thank you very much for the opportunity.

I just wanted to briefly comment a little bit about the member involvement and CalOPTIMA. It was because of the input of the consumers that really CalOPTIMA is in existence today, and I would like to give credit to those people who work so hard on it, but more importantly I would like to talk with some of the things that the committee accomplished. And I must say as a staff person it has not been easy for me coming from the bureaucratic side to deal with the consumer side, but I think importantly as Ellen mentioned the committee was instrumental in the development of the health services requests for proposal. We initially contracted with 34 health plans in Orange County. Unfortunately now we're down to 19, but that process wouldn't have happened as smoothly as it did without our member involvement. They helped us develop the contract and put in the consumer issues that they were so concerned about.

There are also currently, as we talk about

quality, developing benchmark information that they want, that the member advisory committee wants to obtain across all of our networks so that they can obtain the various quality indicators they feel that they need to have to make decisions about redesigning or modifying our program.

Also they have and are working on the design and analysis of our AFDC member satisfaction survey. We have had bumps in the road, some very large, some smaller, with our disabled population. We are mandatorily enrolling the SSI population to the medical managed care program, and they are and our member advisory committee is working with us on our quality management work groups to identify access and barriers to care to help us overcome those. And they have encouraged us to develop such things as wheelchair seating clinics, authorization guidelines such as six-month authorization for incontinent supply guidelines that they feel are really key issues for members with disabilities. They're also interested in standardizing guidelines across the networks so our Medi-Cal beneficiaries when they change from plan to plan the system is same; they're also sitting members on our grievance committee. Approximately 30 percent or three members of our grievance committee are members of the community of our member advisory committee and they helped us develop and modify our grievance and appeals procedure because they didn't like the way we put it together, so they decided to change it.

And again quickly to emphasize the important

role they play, they report directly to our board of directors, they are not a group that sometimes gets together and just sort of pats each other on the back for coming to meetings and eating cookies. They're a working committee and we staff them, we think appropriately.

So those are the few comments I wanted to make.

MR. ENTHOVEN: Thank you.

MR. MCDERMOTT: I'm Steve McDermott, Hill Physicians Medical Group.

When Ellen and Bo proposed the idea of the consumer feedback loop, I had no idea when they proposed it what this thing was going -- what form and shape and how much energy it was going to take. What I will tell you though is after being in the managed care industry for 15 years, it was the first time, amazingly to tell you what an infancy this business really is, it is the first time I was in a room with the health plan and employer at the same time talking about, you know, online real time issues of service and quality. And Ellen will tell you I wasn't exactly thrilled when they said they were also going to add actual consumers particularly when -- and Ellen knows -- how are these people going to be selected? And the answer was, well, it's the squeaky wheel and sure enough a mother of -- who is in Hill with a child who had special problems who had been very, very unhappy with Hill Physicians was the consumer who was put on the task force.

And now having said that, it was a terrific

experience for our organization having both the health plan -- the employer, and I think the more important thing the employer and the consumers themselves on the task force. And we were doing a lot of work at the time anyway but this thing really put octane in the process and made it much more important to us then it might have otherwise been.

Ellen now is saying, you know, because she comes out of the nonprofit sort of community based approach, that it should be voluntary. I'm not sure I agree with that. The benefits of having a lot more exposure to what we do and the accountability that comes from exposure is very important and I don't want to understate it.

The other side of the coin the benefits was it was very clear in the conversations that the employers had very little -- the buyers, if you will, who represent their employees had very little understanding of how the system actually works on a day-to-day basis, and their education and interaction had been largely with the health plans. And as was just said by Consumer Reports is that the product is really delivered by the underlying medical groups and that's largely invisible and it's not 30 it's closer to 300 and it's grossly unregulated and it's at best patchwork quilt. And it's very agonizing and difficult process to create really organizations, entirely new organizations that are trying to attack underlying fundamental problems in the non-system that include

dealing with very intense powerful special interest groups, namely the specialist.

We all know -- do I not pull my punches?

We all know that --

MR. ENTHOVEN: Please continue.

MR. MCDERMOTT: We all know Kaiser -- and I did my original management training in Kaiser in Northern California in 1969 and '70 -- Kaiser is a good system, excellent system, actually, but it is a one-to-one ratio of primaries to specialists. And I will tell you I know doctors in Kaiser who used to be the in private fee for service sector who say I do better medicine in Kaiser. It's more boring; if today's Tuesday, it's gallbladder day, you know, but they have the same team doing the same work with them day in and day out.

I can tell you that there are private surgeons who on any given day will do surgery in three or four locations. They may not know the staff they're walking in on, they may in fact while they're doing the surgery be on all call at two or three E.R.s. This is a historic totally unregulated, unmanaged industry outside of Kaiser. And when I started Hill Physicians in 1985 I literally thought it was going to be -- because I had designed and help build the original 911 and emergency medical system in the '70s -- I thought it would take us 20 years in 1985 to create an organized delivery system, if we could even do it in 20 years of the non-Kaiser sort of rest of the world. And we're 12, 13 years into that

process and I think we're kind of tracking on time, which is sort of good news bad news.

But on our side of the coin, which is the non-Kaiser health care delivery system and non-county delivery system, we're fundamentally dealing with one primary care physician for about five or six specialists and that doesn't work.

You know sometimes I think it would be easier to toll the whole process until all these guys retire and U.C. stops putting out so many specialists, in about four or five years they'll stop doing that, but for those of you like myself who are impatient and very, very unhappy with anybody who has been in health care as long as I have knows all the things that has been wrong with it and they're impatient to get to those issues, then I'm not going to wait for these people to retire. And so when you accept that then you take on a very difficult task and that's the task we're in.

Now having said all of that, as a consequence what I will tell you is we do not have -- the individual PCP capitation is a technique which is used in about 80 percent of the industry, it's pretty much of a bad idea. If you're in business it's a bad idea from a business point of view. Primary care is most care for people most of the time. It's really -- you want really easy access to primary care, and if you capitate your primary care physician it's sort of like the wrong thing to do.

Hill Physicians has never capitated to primary care physicians. We've never done a withhold on primary care physicians. Our primary care physicians are incentivized to see people and see them as much as they can.

One of the techniques in the industry, however, which is, you know, an industry that says managing doctors is an impossible task so let's just capitate them and be done with it; so they capitate primary care physicians and I think a lot of access problems, not all access problems, but a fair amount of access problems comes out or borne out of that sort of technique.

Now having said that, access to specialist is another issue, and I would challenge the thinking process -- and Ellen and I go back and forth on this all the time when she shows her last slide which is, you know, the results are better increased access and increased speed in the referral process. I don't know that that's such a good idea. Too many specialists can be not good for your health.

And so we have, in spite of that, primary physicians and Hill Physicians have been able to do direct referrals to specialists without getting anybody's approval. They can do that. And the specialists have a limited authorizations to go treat without getting authorization. And we also have direct access by consumers to OB/GYN, and for the past two years to mental

health. I think mental health is grossly under funded in health care and Hill Physicians typically spends two to three times what the average medical group spends on mental health because I think it's so unrecognized.

But as far as referrals, once the patient has been seen by the cardiologist or the orthopod that at that moment in time if it's an elective process I want to slow everything down. I don't want to be high noon and mono, mono, okay, so that that patient who walks into that doctor's office, into that orthopedists office under the old regime, the fee for service regime, that maybe the 16th patient that the doctor is going to spend 10, 15 minutes with that patient and make a $25,000 decision. That's not smart; that's not good medicine. But it is the old style of medicine one-on-one. The old sort of sanctity of the doctor/patient relationship, which is a bizarre power curve in favor of the doctor. I want at that point in time the doctor to gather information and then to share that information with other physicians in his own field or her own field and think about it and think about not -- and also I want to remove as much as possible the economic equation.

Now I'll stop, I'm sorry.

MR. LEE: I love this discussion. And we are going to have other meetings of the Task Force and we need to go into the role of medical groups, consumer education issues, and consumer power. And I would love for you to come back and have a discussion about the

interface where medical groups play, etc., but I'm a little concerned about having questions for the other folks that spoke and -- but depending on all the issues we need to come back around and talk about it, but this wasn't the forum for that.

MR. MCDERMOTT: Thanks Peter, I'm sorry, I don't feel strongly about this at all, and those know me also.

And that's the last thing I actually do want to say and that is we make a mistake sometimes in thinking that the shortest period on the authorization process is better and we deliberately at that moment in time if it's elective try and slow the process down and get a lot more information and that's really what we mean by medical review, what some people call utilization review.

Thank you very much.

MR. ENTHOVEN: Bo, do you want to --

MR. CARTER: Steve has conceded me the balance of his time, which is about one hour. I'll be very, very quick.

I represent Integrated Health Care Associations which is a collection of HMOs, medical group large systems, hospitals, plus an academic business purchaser and consumer, and we're basically looking for both policies and projects that will increase the responsiveness of managed care, its accountability, its performance.

Ellen and I talked first about the consumer

feedback ones because we were clearly looking for some projects that had an active consumer role, not looking at patient satisfaction data after the fact and figuring out how you might design a new health care product or new procedure, but putting consumers at the table. So we were delighted to have the benefit of her first model and to be able to create the first one we did, which was Hill Physicians, Chevron, and Health Net, and then the second one with Alameda Alliance and Blue Cross. And we're looking for at least a third one in the Medicare risk arena somewhere in the South.

Ellen has described the benefits of them. I think four IHA as a group our larger interest is to be able, we hope, to create some replicable models and tools. They may not look exactly the same as other health plans or other medical groups or other employers take them on, but if they retain the essential feature of something that is enrollee driven and sets the project from the point of view of the consumer trying to navigate the system, then I think they're going to produce more responsive and lasting result.

MR. ENTHOVEN: Thank you.

Ellen, do you want to come back. The Task Force members have questions.

Yes, Terry.

MR. HARTSHORN: I was wondering for CalOPTIMA has it been around long enough where you can see you're starting to meet some of the original goals which

Ellen mentioned lower cost, better access, higher quality. Have you been able to get any output data?

MS. MARTINEZ: We have gotten some limited data. Unfortunately, we all struggle with encounter data.

What we have seen is a significant increase in CHDP exams for our children; that is something we have been able to measure over time. So that is one indicator.

We're also noticing a more appropriate drug utilization process for some of our difficult to manage patients, our drug seeking patients. So there have been some benefits that we can see right off the bat. But we're now looking at some of the things that you were talking about earlier such as disease state management, programs for asthma, diabetes, etc., for our patients.

MR. ENTHOVEN: Steve.

MR. ZATKIN: I would be interested in getting the thoughts of Jeanne and Ellen about the kind of information that is most useful to consumers in making decisions around health care organizations to the extent to which that is available and how that corresponds to the kind of information that's being developed by purchasers and others.

MS. FINBERG: I think that the -- well, one of the problems that I see or that we see at Consumer Reports and Consumers Union with the efforts that are going on is that they were set up by the industry and by the purchaser's employers, and although there's a little bit more effort now to have a consumer voice in that

system, it's a very weak voice. So one thing that would strengthen those efforts, in our mind, is more consumer participation. We prefer an independent, totally independent evaluator from the industry. So from our view the government or some other nonprofit entity would be a preferable sight because we feel it's more reliable information.

In terms of what kind of information will be most useful, I'm trying to look at kind of what's missing and there's a whole -- most of it's missing in terms of quality measures, and there has been some work in development of outcome measures that's obviously a various complex task and will take a long time to develop, but we need to do it faster and we need to do it better.

One thing that is available now is a lot of the information that the plans themselves are collecting and reviewing and using in their utilization review but they're not telling. And that's the area where I think we could change something immediately that it does exist and if we required some type of uniformity and some type of reporting that consumers would benefit I think probably longer term the industry would benefit too from the uniform nature of it.

MS. SEVERONI: I would just go on to say that at this point the way we are reporting information to consumers just doesn't seem to resinate very well or clearly with them. I mean report cards -- I've yet to have someone call my office, and I get many calls for many

things, but I have yet to have a consumer call and ask me for that kind of information.

I really am -- would like to see us to try to talk with some of the members of the fact team because over the past three or four months they have spent a tremendous amount of money and time doing some very specific research with consumers and, you know, some of the information that consumers want really resinates around which are the organizations which treat me with dignity and respect and, you know, will I be treated fairly and openly. This is the kind of information that people want.

One of the things that I see is that -- and I think I told Allan (phonetic) about this at our first Task Force meeting -- I get concerned sometimes thinking that if you are all bad guys in the industry what you would do is sit back and make all the offices clean and spotless and put smiles on everybody sitting and waiting and treat us in a wonderful way. Because there is an assumption of quality by many, many consumers, and it's because we lack any reliable tools. I mean why would I even as a nurse go up against a physician who has medical quality information or, you know, I don't have any tools that help me do that. And I think we are still years from having meaningful quality information; that's why I'm spending a lot of my time volunteering for an organization that's focusing on organizing that information so it can be put in the hands of people, which I think is -- of

consumers which I think is our real challenge.

MR. ENTHOVEN: Dr. Alpert.

DR. ALPERT: Do you have a sense that consumers are concerned with the amount of time they are seen by physicians, being rushed as opposed to having unrushed consultation? Do you hear that a lot?

MS. SEVERONI: Some consumers. Certainly in any set of focus groups seem very, very tied in to the stories that are in the media. And so it's hard for us sometimes to distinguish are these events that are actually happening to them or are they tying into the stories. And our last few sets of focus groups have been very closely related to a spat of stories that have appeared in the media and so it's hard to distinguish that.

But, yes, people do mention that they believe that -- a lot of the information -- I just want to say this that patients get about the health care system comes from their physicians. And I would say to you that I think if you wanted a very broad-brush statement from me that I think many, many physicians are unhappy here in California in most of these systems because of the relationship between the patient and doctor is still very sacred. Most consumers take that away. So I think if a doctor is feeling rushed and is saying that this is why she is rushed, that's taken away. If a doctor thinks that there's going to be trouble with a referral, or even that you don't need a referral, but they know -- sometimes

we've had physicians tell us in the physician groups it's simply easier to put the blame on to the health plan, to put them blame on to those restrictions rather than risk the relationship that exists between the patient and physician.

It's very hard to look at one group without looking at both.

DR. ALPERT: That is what I was wondering. I'm interested in the fact that, Mr. McDermott, that you are part of this loop and experiment which I'm impressed with and I would like to ask Mr. McDermott. You've described the relationship that Ellen just talked about as sacred as being a "bizarre power curve." You also said --

MR. MCDERMOTT: I did say that?

DR. ALPERT: -- you incentivize your primary care physicians to see patients. How do you do that in light of the issue of perceived lack of time and so forth? How are primary care providers incentivized to see that?

MR. MCDERMOTT: Actually, two things. One is the feedback we get is that they may be not thrilled about the amount of time, but they're more unhappy about the communication. The number one consistently year after year the number one feedback we get back from our surveys is that they are dissatisfied with the type and level of communication. The doctor is --

MS. BOWNE: The doctors or consumers?

MR. MCDERMOTT: Of doctors.

MS. BOWNE: The doctors are --

MR. MCDERMOTT: The patients are dissatisfied with the physician and, you know, the research shows that -- and it maybe tied to the time, okay, it is my belief that it is. Too many of our primary care physicians, because we compensate them on a fee for service basis, are seeing patients that they may not need to be seeing, or frequently have a explicit or implicit mental health issue and they should be seen by somebody else. But they're seeing them nevertheless because that's how they've been trained and that's the compensation.

We have been working on kind of a modified fee for service in which we're doing sort of trying to follow the business group on health and some other folks in which we want to have, as part of the compensation, tied to some of the issues you're dealing with right now. Performance issues, that's number one, because that is -- there's none of that in any of the historic fee for service system. And the second is we would also like the physician to be thinking more about his entire population of patients that they're caring for rather than simply the one-on-one.

And we would also, lastly, like to -- and when I see my primary care physician I would prefer to talk to him on the phone about something and not bother him about it, but he doesn't get paid under fee for service for being on the phone, so that process -- and we're looking at that to tie it in.

DR. ALPERT: Continuing with that, you

talked about having slow down phenomena. I assumed you meant other consultations or you just mean pre-authorization process?

MR. MCDERMOTT: Both.

DR. ALPERT: Usually it's not the pre-authorization process but a singular type of physicians.

MR. MCDERMOTT: I would like to slow it all down.

What we've done over the years is increase what we pay physicians for what we call cognitive codes, that means we're paying our physicians more than the fee schedule calls for to spend time with the patient. We call it the basic history and physical, and spend a lot more time getting to know the patient and talking to them and compress what they get paid for actual procedures and actual tests to achieve that balance and slow that down.

Second thing is to slow down the decision-making process on an elective process to get second, third, fourth -- to get a group of cardiologist to look at the information rather than a harried cardiologist on the fly seeing his 18th patient of the day.

MR. ENTHOVEN: I think we need to move forward. We've got Clark Kerr, Peter Lee, Ron Williams, and Hellen Rodrigues-Trias and then we'll stop it there.

Let's see, Helen.

DR. RODRIGUES-TRIAS: Thank you.

I think many of us have been involved over

the years in efforts to have this kind of consumer participation from the beginning, but that it is extremely difficult to institutionalize it and I wondered how you see the perspectives of that becoming if this is the way to do business -- being that you're needing all of these external outside-of-the-system supports to have any kind of input.

MS. SEVERONI: This is -- that's an excellent question. I certainly haven't figured it out, Helen. In the past few days, in fact, I've been meeting and talking with people about it because the process is expensive and there's a part of me that wants to turn now to Steve and ask him if --

MR. MCDERMOTT: That's a great question and if we had figured it out you wouldn't be sitting here.

DR. RODRIGUES-TRIAS: But what approaches are you having? Obviously what are your thoughts about where should we go?

MR. MCDERMOTT: I think we are sort of at the bottom of the rude and crude process, and I think that the consumer has been really the purchasers, the employer groups, and their interest was in getting the cost down. So guess what, surprise, surprise, that's what everybody focused on. Well, we probably hit that bottom and we're probably actually seeing an increase in cost, increase in premium.

Well, the executives in the corporations are saying, well, now, if you can't show me lower costs then

you better show me something. And so now the pressure is on customer value and so forth. But also we've got to blow past having the employer being the only consumer at the table.

MS. SEVERONI: I can tell you, just to pick up on that, that recently Health Net is the health plan, they were in contracting with Pacific Business Group on Health, and PBGH literally said this looks good but go back and give us a consumer feedback loop and we'll sign on the dotted line. That is the first now I'm hearing that it's not mandatory. It is certainly coming from the purchaser and I guess I was hoping the Task Force would begin to help answer some of that question if you believe there is value in these models.

Your darn right that they need to be incentivized because there isn't enough goodwill to allow that -- Patricia Moore who is the name of the enrollee who sat down with Steve and his team and the other teams over a period of several months, there is not enough goodwill in the world to help an organization through that because that was very painful and I admire all the bodies for coming out in whole and being able to move forward. But it takes tremendous will. So that's where my concern about mandating things comes in because you couldn't mandate Steve and his organization to sit at that table through that. You couldn't make anybody do that. There has to be a way to incentivize this so people who are interested can see the value and move forward and maybe

there's some disincentives you might want to use. I haven't figured that out; I'm hoping we can do that.

MR. ENTHOVEN: Ron Williams.

MR. WILLIAMS: Two comments and one question. One to comment around information that we see in terms of what consumers judge on quality. Consumers judge often by things like parking, waiting time to see the physician, how long it takes from the referral to physically see a specialist, and the whole issue around the communication going to the doctor and what the doctor is saying, and that's a whole set of things that the consumers represent symptoms of quality because they can't judge.

The second point is to echo Steve's comment and put a point on the distinction how health plans pay medical groups and IPA verses how medical groups and IPAs choose to pay physicians. And we talk a lot about capitation and there's an implicit supposition that every individual physician is receiving some per member per month fee for every member in their practice and that often is not the way it actually works. And I just want that point on that.

MS. BOWNE: That's rarely the case.

MR. WILLIAMS: Second question is really for Jeanne. I think that there is still a large population both here in California and in the U.S. that are covered by traditional fee for service plans. You talked about utilization, service, disease management as three critical

dimensions. I'm curious if your organization has done any work to evaluate the implications for utilization services and disease management in looking at the millions of consumers who are covered under fee for services. I would be interested in comments you have had and or haven't had and why.

MS. FINBERG: We have compared indemnity plans and in fact we have done more of that than we have with HMOs who are fairly recent to the HMO comparison mission. But in terms of utilization I don't think that we have directly compared it in the same way for obvious reasons. Although, we did in 1992 a large series which we then put into a book on health care system and did document some of the waste and overuse of the system which, although there was a little bit of managed care then it was primarily the fee for service system that we were illustrating what some of the wasted expenses were. So that's probably the closest that we came in our critique of the health system.

MR. ENTHOVEN: Part of the answer to your question is with the fee for service system on the issue of disease management is there's no accountability structure and one of the things with managed care is there's somebody you can hold accountable for it. I realize your feelings on unequal standard here.

MS. FINBERG: The other thing is too without the lock-in feature of the managed care plan the consumer can walk with her fee to a different doctor, go directly

to the specialist, get whatever procedure she wants, if she's willing to pay for it. So that is an important difference.

MR. WILLIAMS: It doesn't speak to utilization service and disease management and I think the old adage about the attorney who represents himself, there's a statement about that and I think any of us trying to -- there's a corollary statement to those who try to treat themselves. I would encourage us to look at are there similar corollaries in the service and disease management and fee for service system that might be an area.

MR. ENTHOVEN: Clark.

MR. KERR: I think access and satisfaction and dignity and parking and everything else is important, but I'm very concerned about outcomes and I think ultimately that's what consumers are going to be most concerned about and we know there's huge variations of practice patterns in California and around the country. We are also learning there are huge outcomes too and the last six months Johns Hopkins did a good study in the State of Maryland and found in treating G.I. surgeries, gastrointestinal surgery, there were 247 percent differences in mortality depending on the hospital you're going to.

We've had some data, nursing data, reported to us on one of our health commissions that RAND in the last couple of weeks looking at treating MIs, heart

attacks in the State of California, and it was very interesting to note after all the risk adjustments that RAND could do -- admittedly not perfect but RAND is pretty good at doing this kind of thing -- if you looked at the hospitals in California that were doing 200 or more of these a year there was still about a 250 percent difference in mortality depending on which hospital you went to. And if you look down, further down, you get statistically less significant. But if you look at those that did 50 and more heart attacks a year there's 1,000 percent difference in risk adjust mortality.

I think this is critical and I think parking and dignity and all that is important but I think whether you live or die and function is more important and so I'm wondering how can the panelist give us any ideas how we can grapple with what I think is going to be a level of more importance than perhaps some of the other issues.

MS. SEVERONI: My gut reaction to that is basically I do believe consumers can learn how to use that information. It is important. I mean some of the focus groups I've been involved with -- in fact it takes some drilling down, Clark. It isn't up on the top. It takes drilling down into the focus group to get people to think through. It's not natural to think about asking your doctor, well, how many of those procedures have you done? I mean every time my family needs some help I'm sitting there asking those questions and they're horrified to think about asking a doctor those very specific questions.

But I am absolutely encouraged that we can bring people along.

I have wild ideas that, for instance, I -- if I had my way if somebody made me czarina today, I would get the plans together in one room and say let's simply commit an amount of money to public education over the next five years that involves using the media, television, written, every way we can think of talking about quality, of talking about managed care.

I approached some leadership almost seven years ago now and asked them to do that, and I think what we're missing is the fact that there really isn't a broad education effort out there with the public, and if there are ten CHDs we couldn't do this education. It's something that must be committed to, and I'm hoping that that could be one of the things that would come from this Task Force, that we would be willing to sit down with the major players and employers and start putting this information in.

DR. RODRIGUES-TRIAS: May I ask a question though on this issue. I think when you look at those outcome they're special study against special studies, you know, three year studies done by some academic institution. I think what we are going to have to grapple with is not just the outcome discussion procedures, which are easier, much easier to do, verses various dimensions in the outpatient and management of somebody to keep them out of the hospital because they're managing their

diabetes, that's harder to measure. But how do we get a system that generates some of that information on a regular basis so it's not special studies.

MS. FINBERG: I was going to say also I do applaud efforts and agree that life and death is more important than parking. I think we need to have more information and have what information is there out more quickly. There is tremendous resistance to releasing that information, consumers won't understand it. And I find it very patronizing when I hear it said that consumers just want to know about the waiting time or about the parking. We want to know it all. I mean we're all consumers and I'm sure you wouldn't choose your health plan or choose which hospital you went to for your bypass surgery with the information, you know, based on how long it took to wait to get the surgery.

So I think consumers need all types of information and, of course, we want the most important information first; that's where health care providers are the stingiest in providing it and protecting themselves for fear of the negative sides of that information being released.

But in addition to it being helpful for us to choose, it's also helpful in terms of management. I mean it's certainly true that any provider that scores badly in an area is going to pay attention to that area and try to do better next time.

MR. MCDERMOTT: Can I give you the dilemma

and put it back on you to think about.

We know Clark is absolutely right. We actually know a lot more about outcomes than we're putting out. And since managed care, those studies in the U.S. done in Europe and Canada are much more available today, surprise, surprise, than they used to be 15 years ago. So I shoot off a memo to my chief of cardiology in Sacramento chief of cardiology and attached is the New England Journal study that says if you're doing 70 or more angioplasties a year, you have an extremely better rate of success than if you're doing less than 70. And my note isn't it about time that we limit approval of angioplasty to cardiologists that are doing at least 70 a year. All right.

Now we're going to look at that one. Now but think, okay, this uneducated, uninformed public and think about the lawsuits that we will get when I start limiting the practices of cardiologist and or terminating some of the folks that we don't need to do angioplasties any more because we're going to funnel more volume into a fewer amount of people and they're going to do a better job.

MR. KERR: So how can we be helpful?

MR. MCDERMOTT: Let me terminate.

MS. FINBERG: How come you're not afraid of the lawsuits by the bad surgeons?

MR. ENTHOVEN: It doesn't seem to happen.

MR. MCDERMOTT: I haven't been and we fight

those but I'm telling you that's the dilemma we're looking at and that's the issue we're dealing with this week.

DR. KARPF: And how many different states are there than California in developing standardized approach to outcome and publishing? In fact, Pennsylvania state doesn't have much managed care at a time when it had very little managed care put together cost examine council that mandated an information system for everything significant size hospital. It was rather extensive, there was a lot of resistance but they gathered standardized data and they published it on CABG, cardio bypass surgery, on myocardial infarctions and I think, and you're probably much more expert than I, if one tracks that data there has been changes in the variation in that state in facilities because people have responded to that data. So that experiment's been done and people do respond.

I think the question is how do you make sure the data is, one, collected; and, two, that it is in fact standardized.

MR. ENTHOVEN: You're absolutely right, Michael. New York and Pennsylvania are way ahead of us. You can get their good risk for adjusted mortality for bypass surgery, for example, and you have to be careful not to over interpret. I was in a meeting with Mark Chasen (phonetic) on Monday and he said something about we know Redding Hospital has the lowest mortality rate. He said, yeah, but that was last year. This year they're not so good. So there are problems of interpreting. But I

think --

DR. KARPF: I should track that. In Philadelphia you track risk adjusted mortality by changing seats of surgeons. So you can make those kind correlations.

MR. ENTHOVEN: But I think the experience in New York is there has been substantial progress in risk adjusted mortality and it's put a lot of pressure on poor performers.

DR. KARPF: It may be some value to this panel to have some overview of cost containment processes in Pennsylvania and New York and show data. I think we need to get down to the point of looking at some data as opposed to considering anecdotes and personal feelings.

MR. ENTHOVEN: Steve.

MR. ZATKIN: This discussion does point out the dilemma which is whether the consumer's position is to be protective of the rights of physicians and other health care workers and the rights of patients to have access to them. And one can make certainly make that case, or the freedom of the health care organization, to do what was just pointed out; namely, to try to focus on the best of those providers in terms of volume and so on. And it is not a black or white question. I mean it is a difficult question. The legislature right now is wrestling with it and ultimately, of course, you get a balance. But in terms of the public what you get is pressures at both ends, that is pressure to protect due process and

widespread access to all providers, and then at the same time a desire for, appropriately, for enhanced quality, and I just wanted to point that out.

MR. ENTHOVEN: Mark.

MR. HIEPLER: Does Hill do anything to inform consumers? I think the positive thing is that primary care physician is not capitated.

MR. MCDERMOTT: We only started to do that when we began to understand that there was that lack of information so we just started that really within the last three months.

MR. HIEPLER: I see that as a very positive thing --

MR. MCDERMOTT: And that came out of this. I was sitting with consumers -- I was sitting with Chevron and they didn't, (a) know it nor even understand the implications of it and I'm going whoa.

MR. HIEPLER: What we see most of the time and what brings out a suspension of secrecy about the whole HMO industry and some IPAs is they don't know how their doctor is paid, they find out after they've missed a referral, after a tragedy has gone undiagnosed because it's the reverse of what you've described. Generally they're capitated, generally there's huge incentives of one or the other.

MR. MCDERMOTT: There is that in the industry.

MR. HIEPLER: Sure. Sure. But the consumer

doesn't find that out so with the groups that are rare like yours that are incentivizing time and incentivizing the primary care provider to spend time and not disincentivizing, I would think that is a wonderful marketing tool from a positive side because most consumers still think it's fee for service anyway, but those that capitization might have some --

MR. MCDERMOTT: On my agenda for the last two years had been to hire a P.R. firm but we've lost money the last three years and so it always makes it off the table.

MS. SEVERONI: I would also like to say I don't think we should underestimate the sorry state of managed care today in terms of one of the things Steve said which is this is sort of the first time I sat down with the plan and employer and the enrollee at the table. I mean people are so confused about managed care and why wouldn't they be if this is the state of it. I mean these organizations are all dedicated to providing the best care, the highest quality, and the people in them are all I think very fired up to do that. But if they're not sitting down and having a conversation about how to do that and the only time they're getting together is at the contracting time, where frankly I wouldn't want to be 100 feet near those rooms because of the hard balls that get lobbed, I mean it's no wonder consumers are paying for this in some ways.

MR. ENTHOVEN: Peter.

MR. LEE: Tony had his hand up ahead of me, but if I can still make my point.

MR. ENTHOVEN: I apologize, Tony, I didn't see you.

MR. LEE: I'm sorry Keith Bishop is gone. I think there's a great example that sort of demonstrates some of the issues raised by these folks and what we got on our desks when we came here is this is lots of numbers, but it's not interpreted in a way that is user friendly for consumers. This is a great, I think, baby step for starting to collect data, but what consumers need is not pages upon pages of numbers but saying some interpretation, some context. And the points on standardization are important, but I think looking at when we think about getting data, whether it's on quality outcomes or about patient satisfaction, are they standardized, where are they coming from, and how are they useful. I think if you flip through this what you as a consumer can say is now I know more about which plan, another plan from these 87 pages of the full service health care service plans. That's an observation point I said in person to Keith so I'm on the record with him on it too.

MR. ENTHOVEN: Tony, I'm sorry I didn't see you.

MR. RODGERS: That's okay.

The question I have is I'm going to go back to the issue of role of the government verses the role of

the market drivers. Certainly you differentiate your product if you have these kinds of processes in place that bring your product forward and you're cooperating with your consumers, etc. I mean that's marketing 101, but because it hasn't happened what's missing. What you talked about incentives where should they come from? Should they come from government which can say if you don't you can get penalized; or do you believe there's enough momentum in the system to drive it in that direction now? The danger with government it becomes so bureaucratic that you lose innovation, you're stuck in a mold. So I'm going to ask you to give us that point of view because that's in essence is where we have to go and what is the role of government in driving these kind of models if they're the right models to use.

MS. SEVERONI: I don't have the answer for you yet. I need to spend a little more time with the models themselves. I know that it would be important for instance on the Medi-Cal -- in the Medi-Cal work if we're going to find that this is useful and we want to expand it to the other 12 counties, there's going to have to be some dollars there to do it. And I'm not convinced that it has to be the exact process, the consumer feedback loop process that I showed you today because with each one of these projects we find there's different layers and different ways of doing it, but dollars would have to go there. So if we're looking at the Medi-Cal program my guess would be unless we had a very large private

foundation that was willing to put them out there to seed some money that that would have to come from government.

MR. ENTHOVEN: One thing is Jeanne and Ellen are expert resource group on this question, and so I think this discussion has been very valuable and I hope it will inspire you to follow that question like this on both arguments. This is very good stuff here. Now how can we translate that into practical resolutions because as you say if you pass a law that says you have to do this people mechanically go through it. You have to generate the spirit, the desire somehow.

DR. ROMERO: We certainly want to remove any impediments government regulation imposes unwittingly today that has slowed down the creating of these feedback loops or other mechanisms involved today.

MR. ENTHOVEN: I hope they wouldn't have to file a notice of material exchange order.

Okay, Bruce, and then we'll have to stop.

DR. SPURLOCK: I just have a couple of points. I would just like to echo what I said in San Diego, but I think there is a real seductive nature to information and actually it's in comparison to health care because there's an infinite demand for health care and we always want more. We always want more and more for information too, and there's such a seductive nature that you could make better decisions with more health care information. But the -- like health care costs money and we need to think about the value of giving out health

information.

In Pennsylvania, where people are looking at this information, the question is how useful is it to consumers? There is a study going on right now to answer that question and it seems like to go forward and collect information and try to gather data without simultaneous looking at the usefulness and the value returned on that is folly, and I think that's what we have to be very, very careful of it otherwise we're going down that pathway.

The second point I wanted to make was a little bit about what Clark talked about with the outcomes because I'm involved in CCHRI I sit on the executive --

THE REPORTER: You're involved with?

DR. SPURLOCK: CCHRI.

MR. ENTHOVEN: California Cooperative HEDIS Reporting Initiative.

DR. SPURLOCK: We look at outcomes and we look at standardization and we're trying to go into the future, but it looks like there are two different types of reporting initiatives that have to go forward and one type is a general one. It's this data is too much. It's too detailed and we need some kind of general -- something super easy for people to look at from a distance but you also need a detailed report when you're going to have CABG when you're going to have to find out about your surgeon, about your hospital, because that's when it's important. So for the average person knowing the CABG rate is unimportant unless it's going to happen to them. So that

information is two types of information general that is really is something that you can go on forever and be very specific so-called drill down information. And I think we have to have parallel efforts to look at both of those arenas and both of those dimensions of quality information because otherwise we're going to spend tons of money.

MR. ENTHOVEN: Could the record please show that CABG refers to C-A-B-G, which is an acronym for coronary artery bypass grafts, so we're not talking about vegetables.

Thank you very much.

With regret but with hunger I propose that we bring that to a conclusion, and if there is no objection I will forego my summarizing May 30th study sessions and we will forego the executive director's report and proceed right away to new business. Is that acceptable? With the incentive of hunger driving everyone we can move quickly.

First of all we need to adopt the May 8th, 1997, minutes.

MR. PEREZ: So moved.

MR. KERR: Second.

MR. ENTHOVEN: All in favor?

COUNCIL GROUP: Aye.

MR. ENTHOVEN: It's unanimously moved.

Next, adoption of amendments to Task Force bylaws. I would like to ask Alice Singh to briefly discuss the proposed technical amendments.

MS. SINGH: Basically, members, the amendments are very technical in nature. First of all we're authorizing the chairman to create expert resource groups and to appoint members thereto. Second is to authorize set of rules allowing the assembly speaker to appoint ex-officio members to the Task Force. As I mentioned at our May 8th meeting this was simply an oversight on staff's part in the original conception of the bylaws. And lastly we just have a very technical clarification amendment to address the issue of persons voting on behalf of Task Force members.

MR. PEREZ: Mr. Chairman --

MS. SINGH: The amendments are under tab 5 (b) and specifically we have amendments on page 2.

MR. PEREZ: Which are the underline sections?

MS. SINGH: That's page 1. And if you take a look at your bylaws --

MR. LEE: I see the changes related to expert resource groups; I see the change for the ex-officio members. What's the change related to voting?

MS. SINGH: That is underneath the rules on page -- just a moment. It's on page 1 of the standing rules at the bottom, very bottom. It's just a clarification amendment that's made pursuant to the bylaws. The bylaws already stipulate that, we just wanted to make sure our rules corresponded to the bylaws.

MR. ENTHOVEN: Bruce.

MR. SPURLOCK: I have some concerns about the first amendment on page 2 that's underlined expert research groups. And we are talking about this morning with some of the Task Force members and I would like to direct -- see if we can make a motion to direct staff with all haste investigate in detail the two task force member limitation to this amendment. And the reason I'm concerned about that is because I'm fearful with only two Task Force members on the resource groups we will limit the perspectives, and when we bring it back here we will recreate the activities by those resource groups and in this kind of environment. So we won't really accomplish the resource group's full understanding of the complete issue. So there has been discussion about the open meeting to action and the absolute litigation on two members and I want to see if we can direct staff to investigate that issue and really have a very clear understanding that that's all we can have. Because two in my mind just doesn't seem broad enough to give us a good resource group perspective.

DR. ROMERO: Alice, correct my memory if I misremember, but I had this very conversation with you a few weeks ago and I asked in essence what is the basis for the number two and you told me the number is in the legislation as the number two.

MS. SINGH: The number is in the law and we actually asked Ms. Jennifer D'Sheer (phonetic), who is an attorney that has also helped up interpret this particular

act, to verify this particular requirement.

UNIDENTIFIED AUDIENCE MEMBER: You can notice the meeting, it's ten days. Surely you can tell the public that you're going to meet in a larger group within ten days' notice. It's not like you can't meet with larger --

DR. SPURLOCK: I think we go by conference calls so that's the difference.

MR. HAUCK: You can do that if you notice it by the Bagley-Keene Open Meeting Law, state law. You've got to apply the ten day notice --

MS. SINGH: Yes, unless you have a group of less than three members that meet.

MR. PEREZ: I would like to echo Dr. Spurlock's comments because the information I've received from the legislature is inconsistent with the information I've received here as to the application of the Bagley Open Meeting Law, and what I would like to ask is if we could get some advisory letter either from whatever appropriate body we would seek that input.

MR. HAUCK: Get it from counsel.

MR. PEREZ: Yeah, because we are receiving inconsistent information regarding the application. And if I may, to differentiate the establishment of subcommittees or working groups and the size of those from conversations between two or more members of a group of 30 people, and I think those are slightly different questions, and we may get different answers if we ask

those two questions separately.

MR. LEE: I'm still baffled that this is really the rule and I strongly support Bruce.

The other issue though, as a matter of procedure, I think it's important for all the working groups to circulate material throughout the Task Force and whoever are the chairs of task forces can't serially talk to everyone here, and we don't want to all be talking to everyone all the time, which is hard with nine working groups, but one of the charges of the Task Force Staff and of the process is to circulate drafts of material of the various working groups to get comments funneled back to whoever the working group chairs are. And that's a process suggestion though. I absolutely agree we should get follow-up on being able to talk to more than one person at once.

MR. ENTHOVEN: I definitely strongly hope that the people in the expert resource groups will reach out, send drafts to other people, engage them in discussions, get comments, feed them back, and ultimately these papers will be put before the whole Task Force. I find this limitation extremely constraining but given what I was told and understood at the time I figured this is the best way to get around it although -- or deal with it actually, but there's nothing to prevent you from reaching out to several other members on the Task Force and broadening the range of consultation.

MR. LEE: Certainly a more formal, I don't

know about mandate, but to encourage any Task Force to send and draft everything before it comes to the full Task Force as a proposal to have everyone have an opportunity to say before it gets here for group consideration to have an opportunity to have said why didn't they come up with this.

MR. ENTHOVEN: That would be great. That would be excellent if people would do that.

MS. SINGH: Anything -- when we prepare our meeting packets that information is available and so reports and so forth would be available in the packets themselves which would also make them available to the public. We just need to keep that in mind. There's nothing that would preclude us from discussing these issues and so forth we just need to do it in a public arena.

MR. PEREZ: Serial meetings -- my understanding of serial meetings is that they are held to the same standard as a group meeting.

MR. LEE: I don't think serial meetings -- if I send out a draft, here's an outline, if people want to send me back comment they can fax it all to me and I can talk to a whole bunch of individuals and they can say Section 5 seems silly why don't you have a whatever. That's a serial meeting, that's people giving comments, isn't it? Sorry.

MS. SINGH: It's really a gray area and we've asked our counsel, Dale Bonner (phonetic), to do

some extensive research in this particular area because I don't want to say yes or no. I don't feel comfortable doing that, and I've just basically tried to advise the Task Force to be conservative in this respect. I don't want the Task Force to be slapped with some kind of allegation that we're doing something behind the public's eyes. So that's basically --

MR. ENTHOVEN: Are you saying though if Peter wants to circulate a draft to a number of people, does that have to be first noticed ahead of time?

MS. SINGH: No. He doesn't have to notice that, it's just that it has to be made available to the public.

UNIDENTIFIED COUNCIL MEMBER: I would like to encourage the group to think about the tradeoffs between the number of expert resource groups and the public noticing process. If we're going to have expert resource groups that have larger number of Task Force members, which was the original idea, then they simply need to be in a number that's -- we have to have a manageable number of these things. We cannot have an infinite number of expert resource groups that have to be noticed publicly. From a workload standpoint and from a process standpoint it's a waste of managing. So I would urge you if up want to make these larger groups to consider the number of these groups that you want.

MR. ENTHOVEN: I'm hoping that though the members of each resource group could try to make it

virtual large panel by doing what Peter was suggesting, reach out, send drafts, interact, and, of course, the intent is eventually all of these will go to the full Task Force for discussion.

DR. SPURLOCK: I would like to withdraw my earlier motion and change my motion. I want to recommend and make a motion we adopt this amendment; however, I also want to add on that --

MS. SINGH: Wait.

DR. SPURLOCK: -- we adopt the amendment and we direct staff in clear written detail from counsel the activities that we can do under this process which would be including both written and oral communication between members of the Task Force so we can start this process. We can get the two people going, get that process, and if it looks like we can add on more we can have different processes. But I want to have it written in front of my eyes so I know what I'm doing is in accordance with the law.

MR. ENTHOVEN: Could we separate that into two parts? Your first motion was that we approve this --

DR. SPURLOCK: Amendment, page 2.

MS. SING: Wait. I'm sorry. I just need to get some clarification here. First of all, who made -- did anybody make a motion? Nobody made a motion to even adopt the rule.

MR. HAUCK: He just did.

MR. ENTHOVEN: He just did.

MS. SINGH: Okay. Now we have a second?

MR. HAUCK: I second.

MR. PEREZ: I got a question. Was the motion to adopt the specific amendment with respect to these groups or was the motion to adopt all of the amendments that are before us?

MR. ENTHOVEN: Just this one. Just this one on expert resource group.

MS. SINGH: So you're moving to adopt the amendments to the expert resource groups as is; is that correct?

DR. SPURLOCK: Correct. And we have --

MS. SINGH: So what we have to do is we have to have a separate motion. We need a separation motion to do that. I'm sorry, I want to make sure everybody is clear and I'm clear.

MR. PEREZ: Might I suggest we make -- maybe I can recommend a friendly amendment. If you strike on the second line of that paragraph, if you strike the "of no more than two," then the chair has the flexibility to compose these groups of two members, if that's the information we received back as being the legal limit, or more than two members, if we chose based information or based on a desire to notice the meetings to compose them of more than two members.

MR. LEE: I second that amendment.

MR. PEREZ: If it's friendly it doesn't need to be seconded.

MR. LEE: And also to amend the last sentence saying if --

MS. SINGH: Wait.

MR. LEE: I'm sorry, the last sentence of the first full paragraph if expert resource groups contain more than two Task Force members, they shall be subject to all appropriate -- yada, yada. And we're still going to have your follow-up motion to clarify what that means.

MR. ENTHOVEN: So it would say if expert resource groups contain more than two Task Force members the noticing provisions of Government Code --

MR. LEE: Do apply.

MR. ENTHOVEN: Do apply. Both friendly amendments.

MS. SINGH: Is there a second to that?

MR. HAUCK: Second.

MR. ENTHOVEN: All in favor?

COUNCIL MEMBERS: Aye.

MS. SINGH: I'm sorry, first we're going to vote on the last amendment which was Mr. Lee's amendment, okay. So we're clear on that that's what we're voting on first which was to add language into the expert resource section stating that if there are more than two members that meeting will be noticed.

MR. HAUCK: Let me just say that if we continue to proceed in this sort of fashion in terms of an absolute adherence to the technical requirements of Robert's Rules of Order, we're going to tire ourselves in

so many knots that it is outrageous and we don't have to do that. And in this instance we can vote to approve the motion and the amendment together and the minutes can reflect that the motion to approve the -- the motion and the amendment was approved unanimously by the Task Force or whatever the vote maybe.

MR. LEE: Second.

MS. SINGH: I don't mean to be -- I guess --

MR. HAUCK: Alice, I know you don't mean to be but you are.

MR. ENTHOVEN: Alice, just do it.

That takes care of expert resource groups. Now we've got these other amendments.

MR. HAUCK: Mr. Chairman, on the second one, are we there now? The second one is the ex-officio members from rules and assembly?

MR. ENTHOVEN: Yeah.

MR. HAUCK: We've demonstrated more than once how difficult it is to conduct a discussion with a group that's this size. If we add more, I don't care where they're from and I don't care if they can't vote, if they can participate in a discussion all we do is add to the difficulty of what is already a very difficult situation in terms of having meaningful discussions when we have membership of 30 people. And as a practical matter even the limitations on the time the Task Force has to function. I think adding any more people as participants in the discussion is going to make our job

just more difficult.

MR. KERR: Is there any number of suggestions to limit there?

MR. ENTHOVEN: Well, I thought this was ratifying what had apparently been a fait accompli.

MS. FINBERG: I think we adopted this principal.

MR. KERR: I don't have a problem if we are adding 50 people.

MS. FINBERG: Why don't we say no more than five.

MS. BOWNE: No more than two.

MR. PEREZ: Mr. Chairman, the roster I received at our last meeting in Sacramento listed several ex-officio members on the back, some of whom hadn't truly been seated because the bylaws didn't allow for them to be seated. But, for example, it listed Senator Herschel Rosenthal as an ex-officio even though those bylaws hadn't allowed for him. So aren't we really changing the bylaws to allow for people that we already -- who have already been involved in this process to be recognized as ex-officio members?

MR. ENTHOVEN: That's my understanding of what we're doing.

MS. BOWNE: But potentially you're opening it up for them to nominate as many more persons --

DR. ROMERO: Which is why the next amendment.

MS. FINBERG: That's why we'll add but no more than five.

UNIDENTIFIED COUNCIL MEMBER: Seven is fine.

MR. PEREZ: There's eight here but some of them were already allowed by the governor.

MR. LEE: Some of them are mandated.

MR. PEREZ: Right. I think five would --

DR. ROMERO: Mr. Chairman, first of all it's accurate that this is a technical amendment simply to ratify the establishment. The legislature also has the authority to appoint ex-officio members. It was an oversight in the original drafting. The governor appointed a few, the legislature hadn't appointed anybody yet, so we can fix that. I think I would recommend that the Task Force put a limit of either an actual number or in essence a balance between gubernatorial and legislative appointees.

DR. SPURLOCK: I want to make a motion to amend the amendment. And I'm going to say that the Senate Rules Committee and Assembly Speaker may appoint ex-officio members and that the roster of the Task Force will be complete and closed as of June 30th, 1997.

MS. FINBERG: That might be a little bit restrictive if there's a change in personnel or a particular issue within a department. So we ought to give a little leeway, not a lot.

MR. HAUCK: Why don't we eliminate ex-officio members.

MR. LEE: No offense under the table there.

MS. BELSHE': I made that suggestion to Bill; I was kidding.

MS. FINBERG: She wants to go home.

MR. ENTHOVEN: Is that in the legislation?

MR. HAUCK: It says may or your rules say it may, I don't know --

DR. ROMERO: A bit of history for context. When the legislation specified that the governor had 20 appointments and the legislature had ten, five each, the governor felt it was important that certain department heads who have direct responsibility for regulation or health policy be representative of the Task Force, ergo four or five governor's ex-officio appointments, the legislature has responded and appointed two -- is that all we have is two? I prefer to defer to the ex-officios, but I guess one has already spoken. I can certainly find ways to assure you folks add value even if you're not at the table.

MS. BELSHE': I personally think there is value in having ex-officios, it's just you've got more of a political issue with our legislative leadership and the suggestion of having their be parity in gubernatorial --

MR. LEE: I move that as a suggestion. There may be up to parity with whatever is appointed by the governor.

(Whereupon a discussion was had among the council members that the reporter was unable to take

down.)

MR. HAUCK: Based on this list there are one, two, three, four, five, executive branch ex-officio members and currently there are two legislative, Senator Rosenthal and Michael Shapiro. So if you had a total of eight legislative ex-officio --

MR. LEE: No, between Assembly and Senate. Between parity adding together Senate and Assembly they each get half of what the governor gets.

DR. ROMERO: That was generous because they get only half of the total number.

MR. HAUCK: That's an odd -- I mean you have -- you -- now have five executive branch --

DR. ROMERO: So three.

MR. ENTHOVEN: Two and a half.

MR. HAUCK: Two and a half.

MR. ENTHOVEN: Do you want to make a motion to do this?

MR. LEE: Motion is to allow for --

MR. ENTHOVEN: Call up Peter here.

MR. LEE: -- the Assembly and Senate may appoint up to between them the same number of ex-officios appointees as the governor, but no more. And they're not mandated to do so.

MR. ENTHOVEN: Okay. That's the motion.

All in favor?

COUNCIL MEMBERS: Aye.

MR. ENTHOVEN: Anyone opposed?

Let's see. Does that do the --

MR. PEREZ: I have --

MR. ENTHOVEN: John, yeah.

MR. PEREZ: The next amendment is to the standing rules as opposed to the bylaws. I have a couple of issues to raise with respect to the bylaws that I would like us to deal with, if I may.

On page 4 of the bylaws first paragraph it basically says that the procedure for publishing or releasing or attributing information is solely the discretion of the executive director. And I don't find that to be an acceptable rule to govern the publication of findings of a group this size. And I think we should strike approval of the executive director and replace that with approval of the Task Force.

DR. ROMERO: I don't understand your objection.

MR. PEREZ: I'm not saying this would happen, but it could happen, we could make a vote 25, 5 on this report and you could say no.

MR. ENTHOVEN: I don't think that was the intent. The intent was to have editor-in-chief, a traffic cop, so that it was clear what had to --

MR. PEREZ: Right. And that's why the executive director makes written and other reports back to this body, and I think that the appropriate way would be for the executive director and the staff to draft things that they would like to be published or to fine tune

things that we would like to be published. But ultimately this body should have the authority to publish findings as we see fit by majority vote.

DR. ROMERO: The distinction is between editing and the production process verses the publication of vote.

MR. PEREZ: No, I think it's approval. It says -- it specifically says shall be approved, and I think that the approval should lie with the majority of the members of the Task Force.

MR. LEE: Can I suggest a friendly amendment to that? The law of the intent here, I think, is not having Task Force members doing individual things and saying I'm speaking for the Task Force. I understand your intent. I would suggest an amendment that says -- where it says materials distributed by the Task Force shall be approved by -- insert a majority vote of the Task Force or the Task Force executive director. I don't think we're trying to stop a press release or formal announcement.

MR. PEREZ: That's definitely better.

And while we're on that one section if I might add one other thing. In the next paragraph it is says the views -- and it explains what disclaimers shall be accompanied by publications by individuals. I would like to insert the word necessarily so that instead it would say views expressed herein -- actually drop the word exclusively and insert the word necessarily. So it would read views expressed herein aren't of the author and do

not necessarily represent the view or opinions of the Managed Health Care Improvement Task Force.

DR. ROMERO: That's much closer to standard disclaimer language.

MR. ENTHOVEN: Is that a motion?

MR. LEE: Yes.

MR. ENTHOVEN: Second?

MR. RODGERS: Second.

MR. ENTHOVEN: All in favor?

COUNCIL MEMBERS: Aye.

MR. ENTHOVEN: Any opposed?

MS. FINBERG: I have a question now. If the majority is approving written materials like the final document, if in the event we're not in unanimous in our written product, would that allow for a minority report.

MR. ENTHOVEN: Certainly. Absolutely.

MS. FINBERG: But it would have to be approved by the whole Task Force, I think. That's what I'm wondering if we don't need to indicate or minority reports may also be published or something like that.

MR. ENTHOVEN: Jeanne, I would like to say the intent certainly in my mind has been from the outset that minority reports -- we don't want to try to represent, to represent to the world anything different than what is a fact, you know, and I'm expecting in some cases 25 members approve the following recommendations and "X" number of members have the following different view which is presented to the --

MS. FINBERG: But does this allow for that?

MR. LEE: This allows for it at least by saying the views of these five members don't represent the whole Task Force but could be specifically allowed even with that caveat. The members of a minority view could be covered right here.

MR. PEREZ: The other process, right, is that the approval of a report -- we as a body can approve a report with both majority and minority report in the same body so that for example if several of us didn't agree with the majority report, we could attach that so that both reports are shared collectively and then a majority vote would be required to approve both things together.

MR. ENTHOVEN: But I think it goes without saying that our duty is to disclose majority views and minority views. We don't want to sweep any ideas under the rug.

MS. FINBERG: Good. I don't have to make a motion then.

MR. PEREZ: I have one last issue that I would like to raise. With respect to order of business on page 4 where it says the agenda for regular business meeting shall be set by the executive director. Again, there I would like to say executive director or majority vote of the Task Force.

MR. LEE: Second.

MR. ENTHOVEN: All in favor?

COUNCIL MEMBERS: Aye.

MR. ENTHOVEN: Opposed?

Done.

MS. SINGH: We still need to vote on the amendment the standing rule in accordance with Task Force bylaws ex-officio members -- we're adding and other persons may not vote on actions before the Task Force. We're adding and or on behalf of the Task Force member.

DR. ROMERO: A proxy in other words.

UNIDENTIFIED COUNCIL MEMBER: So moved.

MR. PEREZ: Second.

MR. ENTHOVEN: All in favor.

COUNCIL MEMBERS: Aye.

MR. ENTHOVEN: Finally, we must leave some time for public comment, we may have exhausted the members of the public. And if members of the public want to comment we will be meeting at two o'clock here. It would be nice if the comments were postponed until then so the Task Force members can get something to eat, but if Estella Martinez or Ray Ensher want to speak now -- I apologize for the intimidation here but they may do so or alternatively they can speak to happier better fed Task Force members.

UNIDENTIFIED AUDIENCE MEMBER: I would prefer to speak to the better fed.

MR. LEE: I'm sorry, I want to eat a lot too, not a lot. The Task Force resource groups was last on the agenda and I would be curious if we have these

paired already and maybe you were going to distribute something or let us know more about the draft we got.

MR. ENTHOVEN: We have in the meeting packet the list of groups and now I have here -- I've been working it out and it would have been made available to you sooner except that I still haven't gotten yeses on either writing or trying to speak to people and playing telephone tag and I think probably, and in most cases but not all have gotten agreement. Why don't I just --

MR. LEE: Send it out.

MR. ENTHOVEN: Send it out. We have 14 groups, some of them are two person groups; they can meet together. Some are larger which we're thinking can serve as a review panel. But let me emphasize to you the value of people reaching out to achieve balance. I've tried to achieve some -- there's several objectives one is capture expertise and another is achieve some balance. So I will fax this out early next week where we stand.

DR. ROMERO: Two background comments, Mr. Chairman.

The first one is to echo what Hattie was saying earlier when we were discussing bylaw amendments. There are 12 of them -- 14, sorry, 14 groups, each of them had relatively narrow boundary problems, although you might not think that when you get involved with your specific effort, that was to try to make the work handleable with a small number of people. If we -- if you ultimately decide that you need to go to larger problems

and more inclusive groups, then we have the option of noticing them.

The point that I think Hattie was implying and I want to emphasize is that -- and with respective to staff, I just can't be in the position of noticing 14 groups. I can be the position of noticing two or three or four groups or some small number like that. So if you get more inclusive in the processes, you'll have to get more ambitious about identity.

The second comment I want to make, I'll put this in writing but an investigative structure has been suggested to me and I just want to mention now and I will re-emphasize in a letter later I suggest that each of these groups try to answer three questions. And the questions are -- I need my notes. The questions are first of all what is the real or perceived problem that this group is attempting to solve? And then there's some investigation to distinguish perceived from real, obviously.

The second question is what gaps or deficiencies are there in the market and governing structure that's causing that problem or not ameliorating that problem.

And then the third is what roles should various market participants take, i.e., purchasers, plans, consumers, providers, and government to try to address that deficiency.

And then the fourth and final goal which

final question will be a topic of one particular expert resource group that is in essence then how should government organize to fulfill its particular role?

Again, I will -- this is -- I will be summarizing this more thoughtfully in writing, but I wanted to introduce these to you now.

MR. PEREZ: Could you repeat the third one.

DR. ROMERO: Yeah. Third one was in essence -- I won't use exact same words because I don't remember them -- but in essence what role should the various participants in the market and government play in fixing the problem, and as I mentioned were plans, consumers, providers, and employer and purchasers. And I mention that one just to make the point that even though our function is the role of government, I always want to remind ourselves that government's role is simply in the context of the role. It's a number of different participants in this market.

MR. ENTHOVEN: Jeanne, did you have a --

MS. FINBERG: I'll mention it privately so we can eat.

MR. ENTHOVEN: Without objection the meeting is adjourned and we will reconvene at two o'clock.

* * *

STATE OF CALIFORNIA)
) ss.
COUNTY OF LOS ANGELES)

I, Kimberlee R. Miller, CSR 10869, a Certified Shorthand Reporter in and for the State of California, do hereby certify;

That the foregoing proceeding was taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision; that this transcript is a true record of the testimony given by the witnesses and contains a full, true and correct record of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

I further certify that I have no interest in the event of the action.

EXECUTED THIS day of , 1997.

Kimberlee R. Miller, CSR 10869